

FROM TUMULT TO TRANSFORMATION: THE COM- MISSION ON CARE AND THE FUTURE OF THE VA HEALTHCARE SYSTEM

HEARING

BEFORE THE

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FROM TUMULT TO TRANSFORMATION: THE COMMISSION ON CARE AND THE FUTURE OF THE VA HEALTHCARE SYSTEM

Wednesday, September 7, 2016

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:49 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Bost, Takano, Brownley, Ruiz, Kuster, O'Rourke, Rice, and Walz.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. I am going to go ahead and ask our two witnesses to come to the table. Thank you so much for allowing us to take care of a piece of business that was important to both sides. I will now call the Committee to order.

I thank everybody for joining us for today's oversight hearing, "From Tumult to Transformation: The Commission on Care and the Future of the VA Healthcare System." You will remember that the Commission on Care was established two years ago by the Veterans Access, Choice and Accountability Act and it was tasked with examining access to care and how best to organize the Department of Veterans Affairs health care system and deliver care to our Nation's veterans over the next two decades. The commission's final report was delivered at the end of June, and with us today to discuss it and the 18 recommendations it includes are Commission on Care Chairperson Ms. Nancy Schlichting and Vice Chairperson Mr. Toby Cosgrove, Dr. Toby Cosgrove.

I want to thank them for being here today, and I truly want to express my gratitude to them and all the commission members for their time and effort that they put into the important work of the commission. I want to say thanks to the many veterans service organizations and other stakeholders that provided statements for the record for today's hearing. The advice, counsel, and support offered by our VSO partners is vital to the work of our Committee as we work everyday on behalf of America's veterans. I am personally grateful for the input that they have provided me as Chairman and will, I am sure, continue to provide this Committee as Con-

gress moves forward to strengthen the VA health care system for future generations of America's heroes.

Like me, the VSOs and by and large we are supportive of many of the recommendations that the commission has made. The commission rightly recognizes that the current VA health care system has many strengths, many strengths, as well as weaknesses. Moving forward it will be important to ensure that any transformative effort that VA undergoes preserves those strengths, which include in many cases the provision of care equal in quality to that, that is available outside the department walls.

However, VA's weaknesses, which include persistent access failures; non-compliance with Federal prompt pay laws; a lack of accountability; a bloated and self-preserving bureaucracy; and billions of taxpayer dollars lost to financial mismanagement of construction projects to IT programs, bonuses for poor performing employees, and more, are legion and growing. This is evidenced not only by the commission's almost 300-page final report but also by the thousands of pages that made up last year's independent assessment, the years of work performed by this Committee, the GAO, the VA Inspector General, and others, and most importantly by the daily experiences of the millions of veterans who rely on VA for care, are all too often left disappointed.

I wholly agree with the commission's call for creating an integrated VA community care system, modernizing VA's outdated IT systems, better managing VA's vast capital assets, reorganizing the massive and unfocused Veterans Health Administration central office, reviewing eligibility for care in light of the modern health care landscape, and much, much more. However, I disagree, as does the administration and many of the VSOs, with the commission's call for the establishment of a board of directors to provide governance, set long term strategy, and direct and oversee reform. The commission is right to recognize that VA's position as our Nation's second largest Federal bureaucracy carries inherent challenges that are deserving of our detailed consideration. However, given the crises that seem to erupt anew on almost a daily basis where VA is concerned and any efforts to shield the VA health care system from executive and legislative branch oversight is a non-starter. Outsourcing the crucial role of a cabinet secretary to an independent board that is neither elected nor accountable to the American people would be irresponsible in my opinion and inappropriate, not to mention unconstitutional.

The debt that our Nation owes to her veterans is a debt that we all share and the commission's work represents the culmination of a unique moment in history for VA and the veterans that VA exists to serve. There have been and likely will be other commissions devoted to examining VA and how well the department is meeting its most important mission, and that is providing accessible, high quality care to our Nation's veterans. But it is incumbent on all of us not to let the work of this commission fall by the wayside like so many other studies have. And I assured you both, this is not one that will sit on a shelf and gather dust. Ignoring this opportunity would be a dereliction of our duty.

The scandals that have characterized VA for the last several years have opened the door to finally changing the systemic culture

and deeply entrenched problems that face VA and their health care system. Translating that momentum into lasting and meaningful reform will require a commitment to having uncomfortable conversations about how as a Nation we can begin to pay the debt we owe the men and women of our armed forces and to taking the risks that are necessary to challenge the status quo that has left them wanting and waiting.

Whoever sits in this chair after me will be responsible for and I am sure will be more than capable of moving the ball forward, and I am hopeful that today's hearing will help set the tone for that effort. With that, I will yield to the Ranking Member Mr. Takano for an opening statement.

OPENING STATEMENT OF MARK TAKANO, ACTING RANKING MEMBER

Mr. TAKANO. Thank you, Mr. Chairman, for calling today's hearing.

Since we first learned of the wait time controversy in Phoenix, this Committee has been on a path toward reforming the Department of Veterans Affairs.

The passage of the Veterans Access, Choice and Accountability Act in the 113th Congress required the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs. This gave us a good view of the VA health care delivery systems and management processes.

A year later, the enactment of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 required the VA to come up with a plan to consolidate all care in the community programs.

Now, the Commission on Care has released its recommendations for transforming veterans' health care over the next 20 years.

I am pleased to receive these recommendations, but am disappointed the VA was not invited to respond and share its input this morning. Per the legislation, the VA had 60 days to comment on these recommendations and just provided its response to us late last week. I am also disappointed the witness we requested, Commissioner Michael Blecker, was not allowed to join our other witnesses to testify here today. I thought the issues and concerns he raised in his dissent letter were insightful and needed to be part of the discussion as this Committee weighs the best path forward for the VA. I ask unanimous consent that Mr. Blecker's dissent be entered into the record.

The CHAIRMAN. Without objection, so ordered.

Mr. TAKANO. With all the reports and studies we have seen over the last two years, it is clear to me that the status quo, the VA as we know it, is unacceptable.

That said, I don't believe that completely remaking the VA is the right answer either. There is an important balance between transforming the VA while maintaining the services and support that millions of veterans rely on.

I am concerned that some of the Commission on Care's recommendations might in fact weaken the VA health care system. Much like I have seen happen with charter schools, proposals to funnel funding to private contractors and for profit care will take

desperately needed resources away from our veterans, and should be immediately rejected.

Shifting resources to pay for the privatization of care will have impacts throughout the spectrum of care for our veterans. In addition to reducing quality and access to care, it could deprive the VA of cutting edge medical research and IT innovation, top notch clinician training, and stifle the VA's critical role in responding to national emergencies and natural disasters.

We cannot view expanded choice or the private sector as the panacea for solving the challenges the VA faces. Long wait times and workforce shortages impact private care, too. Care in the community should be locally targeted to augment, not supplant the VA.

Instead of stripping additional resources from veterans health care our first priority should be making sure the VA has the staff and resources it needs. Downsizing and dismantling the VA in favor of sending veterans with unique health conditions and urgent mental health needs to navigate the private sector is bad policy.

Lastly, another big concern I have is the cost associated not just with the recommendations made in this report, but with whatever solutions we agree upon that makes the VA more efficient and capable of providing more timely health care to our veterans. It is incumbent upon us to keep the promise we made to our veterans by ensuring they can access their first choice for care, and to defend the rights and work place protections of the 114,000 veterans who work at the VA, and their coworkers, who serve veterans everyday.

Again, I appreciate the work that the Commission on Care has done over the past year, and I look forward to hearing your testimony today. And thank you, Mr. Chairman. I yield back the balance of my time.

The CHAIRMAN. Thank you very much. Members, as I mentioned earlier joining us on our first and only panel this morning is Ms. Nancy Schlichting, the Chairperson of the Commission on Care, and the Chief Executive Officer of the Henry Ford Health System; and Dr. Delos Cosgrove, better known to many of you as Toby, the Vice Chairperson of the Commission on Care and the Chief Executive Officer of the Cleveland Clinic. I appreciate both of you being here with us this morning. And again, for all of the hard work and many hours that you put into the work of the commission. I understand that you are both going to be presenting oral testimony this morning, just as you both had provided written testimony. With that, Ms. Schlichting, we will begin with you. You are recognized for five minutes. And I will tell you that if you do go over and the red light starts blinking, we will not gavel you down because we are anxious to hear your remarks. You are recognized.

Push your mike button one more time because for some reason it is not picking you up.

STATEMENT OF NANCY SCHLICHTING

Ms. SCHLICHTING. Okay. There we go.

Chairman Miller, Ranking Member Takano, and Members of the Committee. Thank you very much for the invitation to discuss the report of the Commission on Care, for your support of the commission over these months, and also the extension of time to complete our work. It has truly been a privilege and an honor to chair the

commission charged with creating the roadmap to improve veterans health care over the next 20 years, and I am very pleased to be here today with my colleague, Dr. Delos (Toby) Cosgrove, the CEO and President of the Cleveland Clinic, who will also present after my testimony.

For 35 years I have served in senior leadership roles in large hospitals and health systems, and for the last 18 years I have been in Detroit at Henry Ford Health System, for 13 years as its President and CEO. Henry Ford is an integrated health system with \$5 billion in annual revenue and 27,000 employees that owns both a large delivery system as well as an insurance company. My experience in leading Henry Ford Health System through a major financial turnaround and navigating our organization through years of massive job loss in Michigan, population decline, and the bankruptcies of our city and major employers while still growing substantially, making major capital investments in our community, and winning the 2011 Malcolm Baldrige National Quality Award have prepared me very well for the demands and complexity of the commission's work.

I am proud to be here today with one of our veterans at Henry Ford, Spencer Hoover, who is Vice President of Planning and Business Development. He served as an airborne infantryman in the 82nd Airborne out of Fort Bragg, North Carolina, with two combat tours, one in Afghanistan and one in Iraq. He was honored with six medals and is now 70 percent disabled as a product of his injuries from combat and training. And Spencer, if you would recognize yourself?

[Applause.]

Ms. SCHLICHTING. Also with me today are the commission's Executive Director Susan Webman and two staff, actually three staff, John Goodrich, Ralph Ibsen, and Susan Edgerton. John and Ralph are also veterans.

Our commission was composed of 15 talented and diverse leaders, two-thirds of whom are veterans. Five have served in significant health system leadership roles, three have served in VA, four have been leaders in veterans service organizations, we had four physicians, two nurses, and even two lawyers. We developed several principles to guide our work, including creating consensus and being data driven, also creating actionable and sustainable recommendations, and most importantly focusing on veterans receiving health care that provides optimal quality, access, and choice.

The independent assessment report that you commissioned was invaluable as a foundation for our work. It is a comprehensive, systems focused, detailed report that revealed significant and troubling weaknesses in VHA's performance and capabilities. Our work took place over ten months with 12 public meetings over 26 days and we sought to have the broadest debate possible and we had intense debate and dialogue over the issues. But our unified focus throughout the process was, what is best for our veterans?

I believe we have produced a very good report, strategic, comprehensive, actionable, and transformative. Twelve of the commissioners signed the report, signaling bipartisan support, and the three who did not had divergent views. Two felt we had not gone far enough, and one felt we went too far.

The VHA requires transformation, which is the focus of our recommendations. There are many glaring problems, including staffing, facilities, informational technology, operational processes, supply chain, and health disparities that threaten the long term viability of the system. Perhaps even more importantly, the lack of leadership continuity, strategic focus, and a culture of fear and risk aversion threaten the ability to successfully make the transformation happen over the next 20 years. Transformation is not simple or easy. It requires stable leadership, expert governance, major strategic investments, and a capacity to reengineer and drive high performance. Some of our commissioners believed in moving VA to a payer only model. They believe that government cannot run a complex health system and that veterans should have the same choice that Medicare beneficiaries have. Yet we believe at the end of the day that VA and VHA under current leadership, Secretary McDonald and Under Secretary Shulkin, are making progress and are aligned with most of our recommendations. And we believe that VHA should be invested in for several reasons.

One is the model of integrated care, much like Kaiser or Geisinger or even Henry Ford. The clinical quality that is comparable, or in some cases better than the private sector. The history of clinical innovation and veterans focused research, medical education, and emergency capacity. The specialty programs, especially mental health, polytrauma, rehabilitation rarely replicated in the private sector. The role as a safety net provider for millions of complex and low income veterans that may not or could not be filled by the private sector in many markets. In fact, as we have seen the implementation of the Affordable Care Act, it has been difficult in many instances to meet the access need simply because of the shortages of primary care physicians and mental health providers in many markets across the country.

Our recommendations fall into four major categories. First, creating a VHA care system which fully integrates VHA, the private sector, and other Federal providers. VHA would continue to provide care coordination and would fully vet the provider network to ensure that veterans receive care from individuals who understood military competency, understood the need for access, transparency of their performance information, and many other critical criteria. We also included the fact that veterans should have a choice of primary care providers within those networks to ensure the ease of access and meeting their needs.

The second category is leadership system and governance, again focusing on continuity and leadership development to ensure sustainable leadership over time to implement these recommendations. And we also recommended a board of directors to provide oversight and the expertise in health care that is critically needed.

We also in the third category focused on operational infrastructure, information technology, facilities management, performance management, human resources and workforce, supply chain, and diversity and health care equity. And finally, we have a category around eligibility, focusing on the needs of other than honorable discharged veterans who have health care needs and in retrospect deserve them, and also eligibility design which has not been looked at in many years and probably would be worthy of taking a look.

The objective of every commissioner throughout this process has been that our report would not sit on a shelf and that in fact it would be implemented. And we ask for your help today to make our report come to life. We ask that you provide VA needed authority to establish integrated care networks through which enrolled veterans could receive care from credentialed providers without regard to geographic distance or wait time criteria. We are asking to address the fundamental weaknesses in VHA governance and to provide VA more flexibility in meeting its capital asset and other needs, including establishing a capital asset realignment process modeled on the DoD BRAC process; waiving or suspending the authorization and scorekeeping requirements governing major VA medical facility leases; lifting the statutory threshold of what constitutes a VA major medical facility project; reinstating broad authority for VHA to enter into enhanced use leases, and easing for a time limited period otherwise applicable constraints on divestiture of unused VA buildings; and establishing a line item for VHA IT funding, and authorizing advanced appropriations for that account; and also creating a single personnel system for all VHA employees to meet the unique staffing needs of our health care system.

I would like to amplify one very key point which other commissioners view as foundational. The commission saw VHA's governance structure as ill-equipped to carry out successfully the kind of long-term transformation required to reinvigorate VA health care. Continuity of leadership and strategic vision cannot be assured under a governance framework marked by frequent turnover of senior leadership and near constant focus on immediate operational needs. The commission believed that two fundamental governance changes were needed, establishment of a board of directors with authority to direct the transformation process and set long-term strategy, and change in the process for the appointment for and tenure of the official currently designated as the Under Secretary for Health.

We are mindful that some of our recommendations have significant cost implications and we worked with health economists in modeling different options. Implicit in our discussions, though, has been the question, should the Nation invest further in VA health care system? Our report answers that question in the affirmative, even as it underscores the need for sweeping change in that system. We do not suggest at all that Congress has not already made very substantial investments in the system. Rather, we call for strategic investments in a much more streamlined system that aligns VA care with the community.

In my judgment, our report points the way to meeting the central challenge Congress identified in 2014, improved access to care while offering a vision that would expand choice, improve care quality, and contribute to improved patient well-being. It is a vision that puts veterans first. My experience tells me that veteran centered focus will ultimately improve the service veterans receive, while strengthening the system and providing increased transparency and accountability. In my view this is a vision that merits your support.

I would be very pleased to be a continued resource to this Committee as you continue on your work. And I would also be very happy to answer any questions, as I know Toby will after his presentation. Thank you.

[THE PREPARED STATEMENT OF NANCY SCHLICHTING APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. Dr. Cosgrove, you are recognized.

STATEMENT OF DELOS M. (TOBY) COSGROVE M.D.

Dr. COSGROVE. Chairman Miller, Ranking Member Takano, and Members of the Committee, thank you for inviting me to speak about the Commission on Care's final report today. As a former Air Force surgeon, I care deeply about the welfare of the Nation's veterans, and I am honored to serve as Vice Chairman of the Commission on Care, and as a Member of my VA Advisory Committee.

Over the course of my work with the VA I have become well acquainted with the department and understand its contributions as well as its challenges in meeting our veterans' needs. As CEO of the Cleveland Clinic, an \$8 billion health care system serving communities across the country and internationally, I am keenly aware of the magnitude of the challenges facing VA health care system leaders.

Mr. Chairman, the veterans health care system must make transformative changes to meet the health care needs of veterans today and tomorrow. If these changes are not made, the VHA's many systematic problems threaten the long-term viability of VA care. The final report contains 18 different recommendations. Today I am going to address four specific areas that include the establishment of an integrated community based health system, quality metrics, information technology, specifically the electronic health records, and supply chain.

Given the commission's charge to examine veterans' access to care, it was concluded early on that greater reliance on and closer integration with the private sector held the greatest promise for improving not only access, but affording veterans greater choice. As you know, the commission considered and debated options that would provide for different degrees of choice. The recommended option in the commission's final report reflects a consensus position, so many supported an option that would provide veterans with still greater choice of private sector providers. The commission agreed that the VHA must establish high performing, integrated community-based health care networks to provide timely and quality care to our veterans. The report envisions a continued role for the VHA health system, but as was said if the challenges and opportunities described in the final report are left unaddressed, we are concerned that our veterans will not receive the kind of high quality care that they deserve.

Among our proposals the commission recommends that the VHA adopt a continuous improvement methodology, such as Lean Six Sigma, to engage staff and improve the culture. This will help but, it will also take significant investments in time, effort, and resources to modernize and streamline such essential functions as

human capital management, capital asset management and leasing, business processes and information technology. The commission recommended that the VHA should implement core metrics that are identical to those used in the private sector. Veterans deserve to know that the health care they are receiving either from the VHA or from the community provider is of high quality. If these metrics are put in place, it will be easier to evaluate the system's performance, and Congress will have a benchmark from the private sector to compare both its progress and improvement over time. Congress and the American people deserve to know that the VHA is getting value for their investment.

Years ago, the VHA was a leader in the field of electronic health records. Unfortunately this is no longer the case. Therefore the commission believes that VHA should transition to the same type of commercial off-the-shelf electronic health records as other providers. By using a proven product, many of the scheduling and building problems would be resolved. Further, these systems could help the VA identify areas of opportunity and utilization to promote better access to care for our veterans and promote interoperability, which is critical as our veterans move to different care sites.

Finally the commercial electronic health record would also allow VHA to link financial and clinical information, a critical functionality for running a modern health care delivery system. The best and most prevalent commercial electronic health record programs allow staff and patients to schedule patient care easily and provide legitimate performance measures for wait times, unit costs, clinical care outcomes, and productivity that conform to those of the rest of the health care industry. Many of our country's best hospital systems have converted home grown information systems to commercially based systems. VHA must do the same to remain current and engage the rest of the health care delivery system. It must also have its own leadership, specifically a Chief Information Officer for the VHA information system that allows VHA to adjust its information needs as the health care industry evolves.

As a VHA contractor, Cleveland Clinic has experienced firsthand the burdensome antiquated system that is currently in place to receive payments. We are required to provide documentation in hard copy form sent via the postal services as they could not accept either fax, email, or other electronic submissions. If a request results in more than 100 pages, we must burn the records to a disc. Because we do not have any mechanism to track whether the documentation has been received, we have heard on many occasions that they never received the paper records and we have no recourse other than to send them again. The independent assessment that Congress commissioned found that the VHA should keep claims adjudication and payment separate from its care delivery.

The health care system that the commission envisions for the VHA will continue to expect exceptional performance from its network of providers and providers should expect timely and accurate payment in return.

Supply chain is another area ripe for VHA streamlining. The commission's report stated that purchasing processes are cumbersome, which has driven VA staff to work-arounds and exacer-

bates the variation and process the VA pays for products. The VA should consolidate and reorganize procurement and logistics for medical and surgical supplies under one leader. The VHA has enough market share to leverage prices that could result in savings of hundreds of millions of dollars.

At the Cleveland clinic, we are constantly evaluating and reviewing our supply chain products and processes. Today, our supply chain is working with teams of clinicians led by a physicians' champion to justify purchases of more expensive supplies by engaging clinical staff in the value-based sourcing effort that illustrates that cost and quality do not have to be mutually exclusive.

Clinicians are made aware of the costs and outcomes are associated with different brands. Once the clinical staff has to justify the higher costs and understands whether it will add value to the care outcomes based on empirical evidence they make purchasing decisions based on value. Such efforts are then integrated into patient-centric utilization management and inventory management efforts to ensure the appropriate use of our resources.

A clinician-engaged, value-based supply chain management practice model has allowed us to save \$247 million over the last several years.

We are continuing to reform our process by entering into purchasing consortium with other nonprofit health care providers and ensuring that we are continually searching for improvements in cost management.

Of course, leadership is the key to transformational change. The Commission speaks to the need to create a pipeline of internal leaders and to make it easier for private sector and military clinical and administrative leaders to serve in the VHA. Market-based pay is critical to bringing in leaders capable of taking the VHA to the next level.

The Commission also proposes that Congress provide VHA a governance board to provide a long-term strategic vision and successfully drive the transformation process. Both the chairperson and I would be happy to talk more about this aspect of the report.

Mr. Chairman, transforming a system as large and as complex as the VHA will require streamlining multiple services, redesigning care delivery and more: this report offers a roadmap to success. Realizing the vision the report proposes will require new investments, both financial and in expertise, enactment of legislation an strong leadership.

Thank you for your attention, and I am happy to address questions.

[THE PREPARED STATEMENT OF DR. COSGROVE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Doctor. We appreciate you both being here.

For either of you that would want to answer this question, do you agree with the President and the Secretaries who have both stated that many of the Commission's recommendations are already being implemented via the MyVA initiative?

Ms. SCHLICHTING. I think that, you know, it is difficult for us to really evaluate that because we are not within that structure at

this point, but I think in terms of strategies and direction, I think there are many areas that are aligned, but it is hard to understand within that, do they have all of the plans that will allow that to be executed, and I think those are the questions that I would have.

The CHAIRMAN. Dr. Cosgrove?

Dr. COSGROVE. Yes. I don't think we can know exactly. For example, electronic medical record, we don't know, have they proceeded to purchase an off-the-shelf electronic medical record or not, which I think is absolutely imperative.

The CHAIRMAN. And neither do we. We are still trying to find that question out also.

This is something that probably other Members won't touch, but I will, since I am retiring at the end of this term, but what do you think the biggest benefit of a BRAC-like process within the VA would be for VHA, and also what do you think the big impediment would be?

Ms. SCHLICHTING. Just a couple of comments on the facility challenge I think that VA has. When we looked at the breadth and depth of all the VA facilities across the country, the average age of a physical plant is about 50 years. To give a comparison, at Henry Ford that is nine years, and I think across the country it is around ten.

So the issues that VA will face over time in terms of their facilities, and also the fact that they are very inpatient-oriented today as opposed to more outpatient-focused are really significant. So we think that the BRAC can provide some objective view and input on how exactly the VHA facility networks are performing today, where the problems are and where change needs to occur. It also could provide, much as it did during the military closures, you know, the opportunity for some objectivity and some protection from the political challenges.

Closing hospitals is a very hard thing to do. I have closed three in my career and I don't wish it on anyone; it is a very challenging thing to do and particularly for Members of Congress who are concerned about job loss in communities that might happen.

The opportunity though in health care is different than the military closures: there is no substitute. So the opportunity for jobs to be preserved in communities through more partnership with the private sector exists, and also the evaluation of other capacity within that community could serve veterans better with lower costs long term. So I think it is with that in mind that we really believe this would help the process.

Dr. COSGROVE. I would just add to that. I also have closed two hospitals and realize how difficult that is and how politically entangled this is as a decision-making process. Also, I think there are over 220 facilities right now that are not in use and have not been either sold or abandoned or begun to be taken down because it has been unable to get that accomplished through the current system.

The CHAIRMAN. And one final thing. There was a statement made in VA's letter to the President regarding the final report that indicated that VA is not in favor of eliminating the current Choice Program restrictions by mileage criteria and the time restriction of 30 days because they desire not to sacrifice VA's four statutory missions. I know the report called for a total elimination of the

mileage and the time requirement, and I would like to ask if you could address why you went further.

Ms. SCHLICHTING. Well, as you know, Choice was a very difficult discussion among the commissioners because we had wide-ranging views around Choice. I think we felt that we had to find a balance because we understood the fact that there was the danger of weakening the current VHA system if in fact Choice was too broad, but what we did do is believe that those limitations in many cases were causing really undue problems for veterans and oftentimes, you know, the timing involved of even being able to assess some of those limitations caused access issues. So we felt that we were erring on the side of choice of primary care provider and also strengthening the VA's control of those networks, because if VA could set up those networks in a way that really created the right capacity, the right access without endangering the ability of VHA to continue their important mission, that was what we were trying to find. We were trying to find that sweet spot between choice and also, you know, the issues of maintaining a system that is critically important.

The CHAIRMAN. I will go ahead and yield to Mr. Takano for his questions.

Mr. TAKANO. Thank you, Mr. Chairman.

You know, many of the national veterans service organizations are very troubled by Recommendation No. 1. They are concerned that instituting Choice as a core policy could lead to a large percentage of veterans to pursue more conveniently located community care, this could end up jeopardizing the viability of unique VA services. Your own economist projected a steep migration to community care.

I have one question for you both. What analysis did you conduct to test how this concern may play out? And second, why did you not recommend pilot testing such a radical change as this?

Ms. SCHLICHTING. Well, we did actually talk a lot about how do you roll this out and felt that probably a phased approach to really test some of the assumptions was important, and there were many commissioners that spoke to that issue.

You know, the execution/implementation is very complex and it will take time, and I think it will require, much as any major change does, some testing and refining and continuing to tweak this. But I think on the choice issue it is important to balance this question of choice and making sure access is really available within every market across the country with the issue of how we are trying to also control frankly, you know, those networks to better serve veterans. So it is really finding that balance that I think is very important.

Mr. TAKANO. The Commission's guiding principles called for recommendations to be data-driven. What specific data did the Commission rely on in recommending that the VA health care system should be organized around the principle that veterans should be able to choose to receive care from a community provider even when the VA can provide the veteran timely care in reasonable proximity to the veteran's home?

Ms. SCHLICHTING. But if you begin to think of the VHA care system in the way that we did, it is not a question of VA versus pro-

vider in the community. It is one system that should be operating in a much more integrated way and every provider that is within that VA care system then would be able to provide access for veterans. So it is a different mind set than today, and I also think should be balanced against all the investments in improving operations that we are recommending within the VHA.

Mr. TAKANO. As you know, the VA health care system is necessarily very transparent when it comes to wait times and health outcomes. How does the Ford Health Care System and the Cleveland Clinic measure wait times? Do those health care systems or for that matter any private health care system post wait times publicly and, if not, why not?

Ms. SCHLICHTING. We actually do now. We have an electronic system where people can call in to clinics and find out wait times for that day for same-day access. And the other thing we have really changed is the whole notion of access. We now believe that same-day access not only for primary care, but specialty care is a standard that we are setting for our health system.

Dr. COSGROVE. And ten years ago we instigated the same-day access. We now see 1.1 million same-day access for our patients and the waiting time in the emergency room from door to doctor is ten minutes.

Mr. TAKANO. So would you expect, therefore, private providers participating in this system in an integrated network to be held to the same wait time rules and requirements as the VA?

Ms. SCHLICHTING. Yes.

Dr. COSGROVE. Yes.

Mr. TAKANO. So I am also concerned about your recommendations to expand Veterans Choice to all veterans regardless of the days waiting or distance, I am concerned that it is financially unsupportable and might in fact weaken the VA's health care system and perhaps significantly increase the share of veteran's care provided outside the VA. Did the Commission look at the costs of these recommendations and how this might affect the vital research and education missions that the VA conducts for the good of the Nation?

Ms. SCHLICHTING. We did look at cost, and we have included estimates in our report around what we think that would mean; it is hard to know, though. I will tell you, there are certain assumptions as you go into these cost estimates that are based on, you know, certain assumptions that may or may not actually come true.

And part of the question is how rapidly can some of the improvements in operations to improve access within VA be put in place, because it is quite conceivable that more patients would gravitate to VA for many reasons, as opposed to always assuming that they are going to go in the private sector. It is not as clear as some people would like it to seem.

Dr. COSGROVE. And I would point out on that last point that there are a number of veterans who currently do not get the care from the VA, if the VA improved its access and improved its ability to take care of them that they would migrate to. There are 22 million veterans across the United States, only six million get some care from the VA. And so the assumptions are very difficult to project.

Mr. TAKANO. Okay, thank you.

Mr. Chairman, my time is up.

The CHAIRMAN. Thank you very much.

Mr. Lamborn, you are recognized for five minutes.

Mr. LAMBORN. And thank you, Mr. Chairman, for having this important hearing. I want to thank the Chair and Vice Chair of the Commission for appearing before us today, and for the time and effort they have put into this report.

We have two main challenges today, as I see it. First, how do we at least ensure that we take what is good in the report and make a reality. One hundred and thirty seven previous reports on VA health care have already been presented and are sitting on the shelf gathering dust.

Second, and this is maybe an even harder challenge, to evaluate whether the proposed recommendations go far enough. We like to use words like transformation and reform, but how willing are we really to challenge the status quo and consider bold reform.

We all remember the managerial failures of 2014 that came to light; the inconsistent care, the manipulated data and other manifestations of dysfunction. And we also remember the words of the independent assessment in 2015, which found that the VHA's systematic problems demanded, quote, "far reaching and complex changes that when taken together amount to no less than a system-wide reworking of VHA," unquote.

So when will we have a system-wide reworking of the VHA? I have a hundred thousand veterans in my congressional district, and I will say that the calls they are giving complaining about VA service haven't diminished and are about the same as it was a couple of years ago before we tried to make and the VA tried to make some changes. They don't believe that things have substantially changed for the better.

With that, Mr. Chairman, I ask unanimous consent that the Commission report dissent from Commissioner Hickey and Commissioner Selnick be entered into the record.

The CHAIRMAN. Without objection.

Mr. LAMBORN. That is one perspective I think we should look at on an opportunity for transformation.

Dr. Cosgrove, I would like to ask you a question about the quality of VA health care. According to the report, quote, "Care delivered by VA is in many ways comparable or better in quality to that generally available in the private sector," unquote. However, the independent assessment found, quote, "on most majors veteran-reported experiences of care in VA hospitals were worse than patient-reported experiences in non-VA hospitals," unquote.

Is VA care better than the private sector, the same or worse? I know that is a very broad question, but it is a very critical question.

Dr. COSGROVE. It is very difficult to answer that. There is only a handful of comparative studies that have been published comparing the two care; some of them suggest that it is better, some of them suggest that it is not equal or not as good as. And I think part of the problem is that they have not been reporting the same as reported in the private sector, and one of the suggestions that

we made and so that you begin to compare the quality is that you have exactly the same metrics as reported in the private sector.

For example, the Society of Thoracic Surgeons reports the mortality rates and morbidity rates of cardiac surgical cases and thoracic surgical cases across the country, the VHA is not a member of that and does not report its—that is not to say that it is better or it is worse, they just don't report.

Mr. LAMBORN. Okay. I mentioned earlier that Commissioners Hickey and Selnick signed a dissenting letter. What accommodations were made to their views, if any?

Ms. SCHLICHTING. Well, both of them participated in all of our discussions and had the same opportunity as everyone to put their ideas forward, which they did. And at the end of the day, we built a consensus around the report recommendations, which 12 of the commissioners approved, and their dissent opinions were included on the Web site as well.

But, you know, with all due respect, neither Stewart Hickey nor Darin Selnick have ever run a complex health system and to say that what we are proposing is not transformative, I think is a complete un—it is just not true. The integration process of creating a VHA care system is a significant transformative process that will take many, many years to complete. Recognizing the complexities of both facilities and staffing issues and leadership, and all of the components that we included in our report, as well as IT interoperability to allow that to take place is very transformative. Neither of those individuals have ever implemented a major change in a health system as Dr. Cosgrove and I have, and I think we recognize the transformative aspects of what we are proposing.

Mr. LAMBORN. Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And I want to thank both of you for your time and commitment on putting this roadmap together. I know it is an inordinate amount of time that you have put in and, quite frankly, all the commissioners, so I just want to thank you for it. And there is much to it that I like very much, and I think it is critically important that we have a clear roadmap by which we can base a discussion. I think this is really the most important discussion this Committee needs to undertake, is that we need to figure out what the transformation is and what it is going to look like for now and into the future.

And I clearly believe that community partnership with the VA is part of the solution. Particularly for primary care and some specialty care, I think that partnership is critically important. I think there are some services that the VA provides that the community can't provide. And so that partnership I think it is really important. And I think as we talk about this, you know, to me, I see it sort of in a sliding scale and where is exactly, you know, the sweet spot in terms of what that partnership really means going forward.

So I really, really do appreciate the report very much and, Mr. Chairman, I hope that we will spend a great deal of time having future discussions on this until we can all come to, I think, a consensus in terms of moving forward.

I wanted to ask, you know, a very specific question relative to the report, because it certainly affects my district. In my county that I am very close to the L.A. medical facility, West L.A. Medical facility, which is a huge facility, and thank you, Mr. Chairman, for your leadership on moving forward with the West L.A. facility. But my veterans also are, by mileage are close enough to the facility, but by traffic and getting there, you know, it can take a day to have a visit.

And so we are working hard to try to expand our VA facility within the district, it has been authorized and so forth, but the way the VA does their leasing arrangement, and you are probably aware of this, is the way the CBO accounts for it makes it very difficult for us or anyone to approve the resources when you are counting a 20-year lease or a 30-year lease all up front.

So I am just wondering, I actually have a bill that is called Build a Better VA Act, but what my bill would do is to sort of harmonize the way the VA does this, the way General Services does this for other Federal facilities, so that we can break down this barrier the way CBO is scoring it. Do you have any comments relative to that or did you discuss that at all?

Ms. SCHLICHTING. Well, probably not specifically, but I will say that around the facility questions, there was a tremendous desire on the part of our commission to simplify and make things more agile for people leading these health care facilities today.

As you know, health care is changing dramatically. There is probably as much change taking place today in the delivery of care as we have seen in 50 years, rapid changes in terms of technology, and where care can be delivered safely and effectively, and the ability to really create those access points from an outpatient facility standpoint. You know, at Henry Ford, we continue to build more outpatient care all the time. I mean, it is a constant effort to keep up with those access needs. And for the reasons you mentioned, that is one of the reasons we took out the time limit and the distance, because every market is different and sometimes you are actually having huge barriers that are unintentional just because of the way that market might function.

Ms. BROWNLEY. I think that is also really important as we look at this that we have to really look at each sort of area and community and region, because everybody is going to have very different needs.

And what about in terms of this vision and roadmap, where does telemedicine fall into all of this?

Dr. COSGROVE. I think telemedicine is a very integral part of it, and the VA has taken a very nice lead in many of the aspects, particularly looking after chronic disease. We think that this is going to be something that will be ubiquitous across the country, and will greatly eliminate the need for traveling great distances.

As you stop and think about the health care system in the United States, it was developed at a time when there was not a lot you could do for people in the hospital, and very poor transportation; now there is a lot that you can do for people and great transportation. And added on top of that is virtual visits, which are going to reduce the travel and the access, and improve the access enormously, particularly in areas of chronic disease.

So we are moving ahead very very fast on that as the VA has taken a nice lead there.

Ms. BROWNLEY. Thank you.

Ms. SCHLICHTING. The only thing I would add on that point is that there is also a lot of digital health development going on today where patients themselves can self-monitor and report information, communicate differently, and that is, I think a great frontier as well.

Ms. BROWNLEY. Thank you very much and I yield back.

Dr. COSGROVE. Could I just add just one thing? You know, going back to the electronic medical record, once you have a commercially available electronic medical record it allows you to make your appointments yourself on your electronic medical record, and that electronic medical record should be available to all patients. And so you have to begin to engage the patients and one of the ways to do that is through the electronic medical record.

The CHAIRMAN. And I do want to salute the VA with the new person in charge of IT with LaVerne Council, I think she gets what is necessary and I hope that that progression will continue.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it. And I thank the panel for their testimony. Thank you for all these great suggestions.

What do you think is a realistic timeframe for the large-scale transformations that the Commission's report calls for, assuming that the VA is already implementing some of the recommendations they claim they are making? When do you think veterans should expect to see meaningful change in the care they are receiving in terms of quality and access?

Ms. SCHLICHTING. I think realistically, we are looking at a five-to-ten-year transformation process, but I also think that any time you go through that, you are looking for those early wins, those things that veterans can see quickly that improve their patient care experience. So there are some things, particularly in the area of technology, and certainly just customer service aspects that can be improved very quickly to help veterans feel more confident in that change process.

Mr. BILIRAKIS. Very good.

Dr. Cosgrove?

Dr. COSGROVE. Yeah, could I just add that I had an experience with changing the culture of the Cleveland Clinic and it took me five years, and that organization was only 80,000 individuals, and something that is as large as the VA, I think is going to take even longer.

Mr. BILIRAKIS. Thank you. Again, building on that, what benchmarks should we be looking for as the VA implements these recommendations, and do you believe the VA has the capability and foresight to track the relevant data?

Ms. SCHLICHTING. Well, I think much like Dr. Cosgrove does at the Cleveland Clinic and we do at Henry Ford, we have a balanced scorecard, if you will, that provides data on a very regular, frequent basis that focuses on our patient-engagement scores, our employee engagement, the clinical quality outcomes. All of the metrics that Dr. Cosgrove referenced that are comparable to the private

sector should be available, I think in a transparent way for people to assess the quality, as well as the service provided in each VA facility.

So I think that level of transparency and having a scorecard that focuses on regular accountable results is very critical in this process.

Dr. COSGROVE. For example, we report almost a hundred quality metrics to the Federal Government on an annual basis and in fact we have quarterly scorecard meetings with all of our department heads going over all of these, the metrics, and I think you have to be a completely data-driven metric organization in order to achieve these transformations.

Mr. BILIRAKIS. Thank you. Understanding that not just one solution will solve all of the agencies shortfalls, if you had to identify to single best—the biggest problem, the biggest problem, what would that be affecting the VA health system, and what is the solution to that problem? The single biggest problem; I know there are several.

Ms. SCHLICHTING. You know, I think all of us felt that this truly is a systems-oriented approach, that many of the recommendations are interdependent, but if I were to put one on the table, I would talk about leadership sustainability, because it is virtually impossible—I mean, Toby has been at the Cleveland Clinic how many years?

Dr. COSGROVE. Thirteen.

Ms. SCHLICHTING. Yeah, yeah, and both of us have served in CEO roles at 13 years in our organizations. When you have turnover in the under secretary position every couple of years, it is very difficult to sustain change, and I think that really is holding back the kind of transformative work that potentially could happen and obviously needs to happen.

Mr. BILIRAKIS. Would you agree, Doctor?

Dr. COSGROVE. Well, I would say that it is one thing that you can do rapidly that will change the organization, and that is the electronic medical record. I mean, that can be done in a short period of time. The rest of the transformation is going to be much longer.

Mr. BILIRAKIS. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you, Mr. Chairman.

And thank you for being with us today. This is a critically important report and certainly at the heart of what our role is, so we appreciate the time that you both have put in and your wisdom.

I want to dive right in. I spend a great deal of time with my veterans and visiting our clinics and hospital during the August district period, and you talk about data-driven and I agree with you, I just want to point out one example of an unintended consequence that we face, many of us around our districts, and that is with regard to the heroin epidemic that is threatening the country. What we discovered and this is broader than the VA, but that the use of quality metrics with regard to bringing down the pain surveys, bringing down the numbers, inadvertently incentivized physicians to push opiate medication, which then led to high rates of addiction. We have a wonderful project at the White River Junction VA,

Dr. Julie Franklin, getting out in front of this with our veterans and I met with a number of them, using alternative remedies for pain maintenance, pain medication, including acupuncture, yoga, all these different criteria.

And I just wanted to see if you would comment both on the risk of being so data-driven that you have unintended consequences, but also your view on alternative remedies within the VA system.

Dr. COSGROVE. Yeah. Well, I don't think there is any question that this measurement of pain as part of the HCAP scores did lead to increased use of opiates.

Ms. KUSTER. And the good news is we did change it, by the way.

Dr. COSGROVE. Yes, I know that you did, and we were instrumental and pushing hard to get that done.

Ms. KUSTER. Thank you.

Dr. COSGROVE. But I think that it is—again, the opiate problem is multidimensional and it is going to require a lot of creative thought. I think certainly other alternatives are going to be part of it, also I think education and expectations of patients is going to be an important aspect of beginning to change that. But this is an epidemic, in Ohio it is a huge epidemic.

Ms. KUSTER. Yes, you have been very hard hit.

Mr. Coffman and I have a bill that we are hoping to get attached as an amendment that would provide a pilot project for VAs to do this type of alternative remedies for pain management. We have had a reduction at this one hospital, 50 percent on opiate prescriptions, and I got to tell you, the one-on-one conversations I had and the quality of life for people whose lives have been turned around. So I just wanted to bring that one up.

Dr. COSGROVE. Congratulations. I think that is a great piece of work.

Ms. KUSTER. Good, thank you.

And the other one is, you talked about the safety net provider and I think that is an important consideration that we can't lose sight of. Many times as I visit our veterans facilities it is the lower-income veterans who don't have access to private care, they don't have access to private insurance; this is their provider of choice. And you mentioned about a shortage of primary care and mental health professionals. I know my colleague Mr. O'Rourke in El Paso will discuss that, but we also have a bill about physician assistance coming out of our military, and I just welcome your thoughts on that approach where we can sort of grow our own and use the skill set of veterans coming out of our military, great experience, and how we could put that to work to reduce the shortage of providers.

Dr. COSGROVE. Well, I would say that the military provides a tremendous workforce for health care. We have hired over a thousand veterans in the last five years, because we recognize that they are highly trained, experienced, and they have a great culture that they bring to us.

Ms. KUSTER. Great work ethic.

Dr. COSGROVE. Great work ethic. And we are delighted to have them and we actively recruit both nurses and physician's assistants coming out of the military and go to the bases to do that.

Ms. KUSTER. Great.

Ms. SCHLICHTING. And I would just add, I think the concept of growing your own is very important within the VA system, because the dedication of the veteran workforce is incredible, and an opportunity I think to really leverage that makes a lot of sense. And we are looking at similar issues around growing our own in areas we simply can't find the talent that we need.

Ms. KUSTER. Great. Well, thank you for your good work.

And thank you, Mr. Chair, for indulging a shameless promotion of my two bills left to be attached as amendments to going forward. Thank you.

The CHAIRMAN. I understand you did a field hearing in Aurora, Colorado about—

[Laughter.]

Ms. KUSTER. And it was excellent, it was great work. I want to thank my Chair.

The CHAIRMAN. Thank you.

Dr. Roe, you are recognized.

Mr. ROE. Thank you, Mr. Chair.

And I want to start out by thanking the Committee that put this together, it is a remarkable piece of work. Thank you for taking the time away from your shops, all the Committee Members. This is probably the most important piece of work I have seen in my almost eight years here in Congress, which could really make a difference if we could implement this.

And during the convention, instead of spending most of my time politicking, I spent an afternoon at the Cleveland Clinic and certainly, and I want to talk about BRAC in a minute, but the way you evaluate your needs is you build the needs to the modern health care system, and the entire health care system is undergoing radical changes in the U.S. right now, a shifting from the concrete silos to outpatient, more and more surgery. I mean, a hundred-bed hospital today can do what a 500-bed hospital did 30 years ago. I think the VA is still stuck at the 500-bed.

A couple things. Let me just summarize what I have heard so far. One, I believe that to move this system forward we need an integrated care model that involves the private sector and the VA sector in primary care; and, two, Dr. Cosgrove you pointed out that to have an electronic health system that is 20th century. I think that we had this debate sitting right here, I remember this, three years ago where DoD and VA tried to make these two antiquated systems interact and they could not. I mean, I have been all over the place trying to see how these experiments failed.

A modern system solves a lot of the scheduling problems, payment problems, data problems that you talk about right now. They have done a remarkable job of working around these problems, but there is new technology out there and the DoD made that decision. The VA sat right there and tried to convince the DoD to put in a 30-year-old or 20-year-old system and they didn't do it, they went ahead and took it off the shelf. So I think that would be something they need to do. That solves your supply chain, all those things we talked—it doesn't totally solve it, but helps solve it.

And lastly, I think is the BRAC. And it may be my last term too, but you can vote for the BRAC and the gas tax, and you probably won't be here can. But I think we have to sit down and evaluate

what those assets are and where you can get the best care. If the best heart surgeon is the Cleveland Clinic, it is about providing the best care for veterans. I think that is what this is all about; not sustaining a bureaucracy, but providing the best care and where that care can be given most cost-effectively.

So I admire what you have done. And to say our Committee has not provided the resources for the VA, when I came here in 2009 we spent about 95, \$97 billion on all VA care, cemeteries, disability and health care. Today it is 165 billion without choice. I would say that Congress has done a job, it is just that—and we have gone from 250,000 employees to 330. And in the private sector you have had to figure out how to do it more efficiently with less people, because your revenue, I promise you, has not been going up like it did, you had to better manage. So I commend you for that.

And my last question I want, do you think if we can come to the consensus those four things I have pointed out, and it won't be easy, and we pass it, do you think the VA can carry it out? And I know that you said, I hate to put you on the spot, but you pointed out that leadership is the key for transformational change; is that leadership there?

Ms. SCHLICHTING. You know, I think leaders get better over time also. You know, the current leadership has been in place a very short amount of time actually and have, I think, made some progress in key areas and have set the right tone for improving access. But I also think they need some time and it is hard to judge whether that can happen unless there are sustainable leaders in place, which is why we recommended the idea of five-year terms for the under secretary, and having that individual actually selected by the board of directors, so that that process can move forward and that individual feels the support of a group of people that are really trying to move transformation forward.

I recognize that that may be unconstitutional. There may be ways around that that can help with oversight, but—

Mr. ROE. That hasn't stopped us from doing a lot, the Constitution hasn't—

[Laughter.]

Mr. ROE [continued]. —before, but the question is do you think we can? Because I think this is a remarkable document, and I think it has a chance to put veterans and doctors back in charge of their care and not a system. And I just wonder if you think we can do it, because if you could, I think you would truly transform the health care system that veterans receive.

Dr. COSGROVE. I think it is going to take time and this is not going to be quick, this is going to be incremental, and it is going to take continuing change of a very big system.

Mr. ROE. I think the key one is making a decision on the EHR. I think that that one is one that begins to solve a lot of these other problems you are trying to do with different software systems now that don't work well together.

Dr. COSGROVE. I think, you know, I would just say one other point to move to that. You know, we have and many people around the country have learned that you can't maintain an electronic medical record in an individual facility, it is moving too fast, and that is why the commercial aspect of this has kept up with the

changes and made them uniform across the country. So I think it is absolutely imperative.

Mr. ROE. Okay. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I would also like to thank the Chair and Vice Chair for their work and the sacrifice of their time, and frankly their commitment to their day jobs in order to be able to fulfill this commitment to the veterans in this country and to the American people. And I really appreciate the way in which you conducted the review and made the recommendations. And so I just want to add my thanks to all my colleagues'.

I would like you to discuss what I think is the most pressing crisis facing our veterans in the VA and the single greatest unmet need right now in the system, and that is the tragic number of veterans who are taking their lives every day in this country. The new estimate from the VHA after looking at data from all 50 states is that it is 20 veterans a day who are taking their lives. I think that is the single greatest opportunity to stop these preventable deaths, if we take this seriously, confront it and organize to provide far better care than the care that is being delivered to veterans right now.

As I hope you remember from our discussion, in El Paso, because of the high number of veteran suicides, the inability for too many veterans to be able to see a mental health care provider, never mind the wait time, originally estimated at 14 days, we now know it is over two months on average, but a third of veterans in El Paso couldn't get in at all. That has prompted us to propose a solution in El Paso that we are trying to pilot right now to focus VA care specifically, that care that is delivered in-house on those conditions that are unique to service or combat, and PTSD, traumatic brain injury, traumatic amputations, military sexual trauma, there is a long list of these, that I believe we want someone who knows how to treat veterans, perhaps only treats veterans and active duty servicemembers, knows the things to look for, the questions to ask, the treatments to prescribe. Is there a way to resolve that idea with this idea of a network where you do leveraged capacity in the community? And for those conditions perhaps that are not connected to combat or service we prioritize community care, but for those conditions that are unique to that experience of being a veteran we make the VA the center of excellence for the treatment of those conditions.

I would love to get your take on that idea.

Ms. SCHLICHTING. Actually, we agree with that. The recommendation that we put forward really focuses on those unique capabilities of VHA absolutely being supported, invested in, continue to grow and develop, because it has been shown, my understanding is that it has been shown that those veterans that actually seek care within the system end up with a much lower suicide rate, because they are being managed, their care is being managed and they are in touch with health professionals who provide that kind of support on a daily basis, which is really critical for those types of needs.

But unfortunately it is how do you embrace and get people into the system who otherwise may not be willing to go there, and I

think that is one of the challenges. And you are right about the fact that in the private sector doesn't mean that people are well equipped to handle the complex mental health needs of veterans. In fact, in many cases we have the same problems, if not more acute problems of having enough mental health providers in our community today.

Dr. COSGROVE. And I would just say that I think there are a couple things that begin to recognize what Nancy's last comment was, is the shortage of mental health providers. Increasingly, I think you are going to see virtual visits begin to augment the shortage and help the shortage of mental health providers, and similarly group visits and group therapies for those individuals, and we have found both of those to be very useful.

Mr. O'ROURKE. You know, I think as long as we can prioritize that excellence in care around those conditions, especially those that could potentially lead to veteran suicide, and are able to reduce the number of veterans who take their own lives, improve outcomes, improve access, I think the system that you are proposing makes all the sense in the world.

We learned this summer that the VHA has 43,000 positions that are authorized, have the funds appropriated for, but are un-hired today, and we are fools to believe that we will ever hire all 43,000 of those. So let's prioritize within the VA on those areas where we can do the most good, make the greatest positive difference for those veterans, and for me that is clearly mental health and reducing the number of veteran suicides.

And then we face another issue, which you raise, which is how do we produce enough doctors in the country generally to ensure that we have capacity for veterans in the community. But I think if we can leverage the two, what we should do really well in the VA with what exists in the community today and follow our Ranking Member's lead in creating more graduate medical education positions, then I think we are going to be on the path to fixing this.

So my time is up, but again thank you for your work on this, I am really grateful for the effort.

The CHAIRMAN. Dr. Benishek, you are recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

Well, I thank you so much for the great work you did. I don't know exactly where to begin with all the things that have come up today.

And the two things that strike me from your testimony and your answers to many of the questions is, Ms. Schlichting, your comment about the leadership and how critical that is to transforming the VA. Having not so much a political appointee at the head, but having a board of directors like a regular hospital, like a regular system that, you know, people are on the board, I was on a board, and then a continuity of care over a period of time so that these things can be developed, I think that is critical.

I think it kind of behooves us to make that happen and I see that as a challenge to this Committee to take the bold steps necessary to basically implement your plan. I don't want to say I agree with everything, but if we don't do this we are going to be faced with 30 more years of the same thing we have been doing now, and I

think that is the critical takeaway from this very important commission's work.

And the thing that you said, Dr. Cosgrove, the other thing I take away from this is the critical need for an IT system that makes sense. I mean, to me that is your testimony from the two of you is leadership and immediate action on an IT system which, you know, really can be changed.

I just want to bring up a question that always bugs me and that is, when you estimate the cost of implementing these things, how did you estimate the costs of the VA care? Because when we try to figure out what it actually costs the VA to see a patient, you know, in the private sector we know what it costs to see a patient, all right? But the VA doesn't do that. How did you estimate that? Because we haven't been able to get a figure on that.

Ms. SCHLICHTING. Well, let me just say that one of the things I think that probably struck all of us that are in the health care industry was how little focus on cost VA has. And that was sort of shocking because we live in a world where we have to constantly focus on costs per unit of service, costs for, you know, a full episode of care over time, creating, you know, population health management techniques so that we in fact can understand cost and whether we are contributing to value and improvements in quality, and that doesn't exist today within a budget-oriented VA system, and I think that is one of the challenges as we looked at this cost question of how we move forward.

So I think one thing that probably should have been in the report that wasn't was this notion of getting more cost-oriented in terms of some of the metric around performance.

Mr. BENISHEK. Well, that is my frustration here, is what does it cost the VA to see a patient, there is like no clue.

Ms. SCHLICHTING. Yeah. And in fact, if you look at the model, I mean, and look at what is changing in health care today, you know, we are getting away from the volume-oriented kind of measures. We are trying to focus on outcomes of care, you know, clinical results, as well as are we making a difference in terms of just the efficiency of care that we provide.

So it really, I think this is part of the transformation. And Dr. Cosgrove pushed very hard on this during our deliberations of how do we get metrics that are more comparable so that in fact we can determine the effectiveness of the VA system over time. But I would add that I think, you know, if you view this in phases, there are ways to test some of these assumptions and begin to look at those cost elements that could be projected out over time so that you can really see.

The other thing is this issue around facilities. If all the facilities had to be replaced versus creating this integrated model, there is a lot of potential cost savings and cost mitigation over time that I think would help.

Mr. BENISHEK. Well, the only thing further I want to bring up and it is related to the status quo of the VA, now one of my big complaints is that working there, I had very little input as to how things worked in my clinic or in, you know, making sure that things ran efficiently. It seemed like others who weren't really involved in the patient care were making the decisions as to, you

know, how many staff to have, how to make the staff flow, you know, I mean patient flow and all of that. So I think that would come with the leadership changes.

But is there any other comment that you would like to make on that, Dr. Cosgrove?

Dr. COSGROVE. Yeah, I just think that you need to bring physicians more into every aspect of delivering care and running the organization. I gave the example of purchasing, previously physicians were not involved in that; we found tremendous efficiencies by bringing them in. And without involving physicians in the leadership of the organization, I think you are missing an intellect and a set of knowledge that is necessary to have a high quality organization.

Mr. BENISHEK. Thank you very much for your work, and it is up to us to get this show on the road.

The CHAIRMAN. Thank you, Doctor.

Miss Rice, you are recognized.

Miss RICE. Thank you, Mr. Chairman.

Would either one of you want to be the Secretary of the VA by any chance?

[Laughter.]

Miss RICE. Just out of curiosity.

Dr. COSGROVE. I had that opportunity, thank you.

Miss RICE. So I just want to echo some of the comments that Mr. O'Rourke made. We recently had a veteran take his own life in the parking lot of the Northport VA, which is so disturbing, and so I couldn't agree more with Mr. O'Rourke about this being such a top priority for the VA to handle.

I also totally agree with Dr. Benishek that the two issues in terms of accountability and the electronic health system, records system, are critically important. I mean, every single hearing that we have, the number-one issue that we talk about is accountability, whether it is for how whistleblowers are treated by higher-ups, wait times, the enormous cost overruns for construction projects, you know, the list goes on and on and on.

And it seems to me, Ms. Schlichting, if you could just address the whole issue of how you would create a more effective hierarchy. The board of directors, how would they be chosen? Why do you say that the Under Secretary of Health position should be one that has a fixed time limit versus the Secretary, somewhat similar to the head of the CIA and the FBI, right, that have set times?

I mean, if you could just talk more about that, because to me, I mean, I don't know if that will get to changing the underlying culture of the thousands of employees who are under the Secretary and the Under Secretary, but if you could just talk a little bit more about that.

Ms. SCHLICHTING. Sure. Well, first of all, culture starts at the top. There is absolutely no doubt in any organization that the tone that is set and the way it is deliberately carried out every single day in decisions, in reaction to things, in how, you know, leaders respond appropriately to the needs of an organization, I think is very, very important.

And as we look at the VA and you have again someone who is really running the health system, obviously the Secretary is re-

sponsible for all of the veterans functions, but the health system, at least the way we understood it, is run by the Under Secretary of Health from a, you know, operational standpoint, and yet that position has turned over repeatedly. And so the ability to set that tone and follow through on a whole host of strategic initiatives and making decisions on a daily basis gets cut off and then the next person comes in. And it is very hard for an organization other than to hunker down and sort of wait for the next leader, it is very hard for an organization to embrace those kinds of changes.

The reason the board is in our view very important is, first of all, the board stands behind that individual and helps them be better. They are there for a broad base of input, expertise, again that level of accountability, which happens on a more regular, routine and organized basis. So that board sitting there saying, you know, we thought this was your strategic plan, it is not to usurp Congress, but it is to get that performance up. Congress ultimately is responsible, has the power of the purse, and all of the other aspects of your authority, but the idea is to bring some health care expertise in and other leadership to engage that CEO on a regular basis to make the kind of changes that are necessary.

Miss RICE. Thank you.

Dr. Cosgrove, the electronic health records, just what has been the problem within the VA in terms of addressing that issue?

Dr. COSGROVE. The VA started out by developing one of the first and best electronic medical records, and over time, I think they suffered from the same problem that Massachusetts General Hospital did, Johns Hopkins, Mayo Clinic, Henry Ford, that they could not keep up with the changes that were needed across the organization. And so there are now 130 versions of that electronic medical record across the system, and that has fallen behind in its capabilities, and also has not added the sort of capabilities that you now see commercially available. And it is time to do the same thing that many other organizations have done, and abandon the home-made project simply because there is not enough IT expertise within the organization to keep updating it.

Miss RICE. Right, right.

Well, I want to just echo what everyone, every Member of this Committee has said, which is to thank both of you for really your Herculean efforts, and my hope is that all of us here are going to be able to see the wisdom of your report and begin to implement it in a way that is not partisan at all, because the bottom line is giving the kind of health care to the men and women who served this country that they deserve. So thank you very much.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman.

And thank you both for your tremendous work on this, it is just incredibly important. I am looking at Recommendation 10 when you talk about changing the culture of the VA and it is such a corrosive culture. I mean, if we look at the appointment wait times scandal where appointment wait times were manipulated to bring them down by denying veterans care and maintaining these secret waiting lists so people could get cash bonuses, I mean, number one,

nobody was ever prosecuted for that, and it was systemic, and number two, nobody was even asked to give back their bonus.

And so when you have a system where it literally takes an act of God to fire somebody, and where it seems like the only people who are disciplined and fired are the whistleblowers who bring these problems forward, I mean, it would seem that the route of the problems at the VA lie in the culture of the VA. I just wonder if you could respond to that and some of the internal discussions maybe you had that aren't necessarily in this report in terms of the range of views on your commission.

Ms. SCHLICHTING. Well, there is no question the independent assessment report commented significantly on the problems of the culture of the VA. I think we felt very strongly that in order to change culture you have to make sure, again, sustainable leadership has to be in place and leadership that people have confidence in, that are going to make those tough calls and make those decisions that are appropriate.

Mr. COFFMAN. But if leaders can't—that it becomes so difficult to get rid of subordinates.

Ms. SCHLICHTING. Well, I am not sure I believe that, you know—

Mr. COFFMAN. But that over time that people just don't even try.

Ms. SCHLICHTING. Well that is the problem.

Mr. COFFMAN. Yeah.

Ms. SCHLICHTING. People, frankly, and I have seen it in our own organization that people say, well, we can't fire people. I said, oh, yes, you can; you have to work at it.

Mr. COFFMAN. Right.

Ms. SCHLICHTING. You have to make sure that you are going through the appropriate discipline process, that people are given due process, which is important.

Mr. COFFMAN. Sure.

Ms. SCHLICHTING. But that you have to do it. And that is about leadership development at all levels; that is not just at the top, that is front line supervisors, that is managers and people that really are going to make those decisions on a daily basis about the quality of their workforce and their decisions and getting it done.

Mr. COFFMAN. But also it seems like the leadership of the VA, that leaders when they are responsible don't take responsibility when wrongdoing occurs and are never held accountable. So we are talking about not just the rank and file, but we are talking about the top of the authority—

Ms. SCHLICHTING. But my sense was that a Secretary was fired over that and when that did happen, that is when Secretary McDonald came in. So I think clearly there was a decision made that reflected the seriousness of the problem in Phoenix, but I also think people need time to change that culture.

Dr. COSGROVE. And I think you also have to invest in leadership training and bringing people along, and I think it goes into a couple of categories. I think it goes into the category of experience with feedback, which is difficult and painful sometimes to get and to give, and the second thing is they have to have a certain amount of intellectual training that goes with that, and it may fall into the 80–20 or the 90–10 ratio. But nonetheless, you have to have an ac-

tive leadership, education and training program, which is non-existent right now.

Mr. COFFMAN. Thank you. And I don't know how we ever really have a full discussion about transforming the Veterans Health Care Administration when we don't know what their costs are for any given specific procedure, and as a Committee, we have requested that. And it is stunning that they either know it and don't want to give it to us or they don't know it themselves. What do you think the case is? Do you think they just don't know it or do you think they don't want to give it to us?

Ms. SCHLICHTING. My sense is that that needs to change. And frankly I think it has been based on, you know, a focus on a year-by-year budget process as opposed to in our world, we rely on revenues to set the level of expense. So we have a very strong focus on cost, this is a very different model. And I think frankly it would be helpful to think about how to get that cost focus more directly built into the process of the budget and how, you know, they justify expenses.

Dr. COSGROVE. I also think there is a matter of collecting the data and, if you don't have the data, you know, you can't understand it. And that data includes the severity of the illness, all of that goes into determining how much cost per veteran to take care of them.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you.

Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Mr. Chairman.

And I too want to echo my thanks to both of you. You did exactly what we were hoping would happen in that conference Committee when we created the Commission of Care and the request for it that you would come up with specific recommendations to improve veterans' care, but you would also help facilitate a national dialogue that was sorely missing in a transformational type of way.

I represent the Mayo Clinic in Rochester, Minnesota too, and they are like many of you, and they will say there is different models. Cleveland Clinic, Henry Ford, Kaiser, there are others that do it, but there are certain fundamentals that are true throughout all these organizations and how they deliver that, integrated clinical practice, education, research, and then that focus on leadership.

The one thing that I think is so refreshing about what you came up with, and I will hit on a couple of those points you brought up, I remember ten years ago asking why we did a quadrennial defense review, with an understanding that the world of 1986 looks entirely different than the world of 2016 from a resource-allocation perspective to how we would defend this Nation and all of that, but never done on the VA. So we plodded on year to year, year-to-year budgets. We actually did something I thought was somewhat innovative and it took a stretch from this Congress to do advanced appropriations to give a little more continuity to that, to make some decisions like your organizations make decisions, but it challenges us in ways that we haven't been.

And I also want to thank you, and I think, Dr. Schlichting, you are doing a very good job of stressing this, trying to remove this simplistic argument of public versus private sector, or the idea that

VA health care can be discussed in a vacuum outside of health care in general. This gives us an opportunity to holistically change the entire system. And we know that there are going to be assumptions that maybe don't pan out the way they went, you know, lo and behold, we find in the ACA that a lot of people who didn't have health care insurance before, like to go to the doctor now, and some of them were sicker than we assumed in some cases. Those things have an impact and instead of just fretting or pointing fingers, let's come back and find a workable solution, and that is going to challenge all of us.

I wanted to hit on the first one. This one just has me tied in knots, the board of directors issue, because I absolutely hear where you are coming from, if I go to Mayo Clinic they will say this is a great suggestion, I can guarantee you, just like you are saying, because the one thing is they are saying, Tim, you may have some expertise in geography or China, artillery, and each of these Members brings their own thing, but have you ever run a large health care operation? And as a Member of Congress it is our job to try and gather and learn as much information, and we are ultimately responsible for the oversight. So there is a real hesitancy to give away what feels like giving away that authority, but the need to put that in there.

Now, this has been challenged on the constitutional issue, it has been challenged for all kinds of reasons. How important, if I could ask you, do you believe that mechanism is for transformation? If we are going to fight this fight, it is going to be big and it is going to be transformational with the big T. So how do you see it, if I asked you, if we do this and, you answered a little earlier, do some of these recommendations separately, but you really need to look at holistically, how important prioritized is this board of directors?

Ms. SCHLICHTING. I will tell you that probably of all of the recommendations, this had unanimity among our commissioners, and I think it was felt to be, if not the most important, one of a very small number of the most important recommendations that we came up with.

Mr. WALZ. Dr. Cosgrove?

Dr. COSGROVE. I completely agree. You know, the fact that you have over 500 people trying to run the VA seems a little much.

Mr. WALZ. This may be an Achilles heel of democracy, but we are ultimately responsible to the taxpayers, we ultimately have to do that. Giving away that authority even to a Secretary is very, very hard to do, and then giving it to another layer in there. But I am with you on this that I am certainly willing to have this discussion. And behind you there is a whole room full of folks who have spent decades supporting veterans; they are not in opposition to this, they are there to ask these hard questions about this recommendation, how is it going to impact.

But my question to you too—and I could not agree more, this sustainable leadership. I have seen it at the macro level, I have seen it at the micro level, in the VA and outside of this, that it is absolutely critical. We are going to have to restore some trust that people want to go to work there, that it is not this assault on the integrity of everyone who is there and to see a unified commitment to getting this. How many of these things do you think should be

implemented, even if they could be, through internal rulemaking on the executive side? I always make the argument on this, that I think we are better off if we do it. We keep responsibility, we have ownership, and we have the American people behind us. It takes a while, but do you see that we should just enact some of these and get moving, or should we have this national debate and fix it through this way?

Ms. SCHLICHTING. Well, I am not the expert on the rulemaking at all, but I think that our staff really identified in the report those areas where Congress really does need to take action, and those areas we felt could be done within the executive branch.

But, you know, the truth is, as I think everyone in this room acknowledges, this is a bipartisan issue. These are our veterans, it is critically important that we find a way to deliver better health care, and we felt strongly that in the area of leadership and governance that new structures were needed in order to provide that oversight, whether it is the IT project—I will tell you, at Henry Ford we had a special Committee of our board to oversee the implementation of the Epic system, and without that, I am not sure we would have done as well.

Mr. WALZ. Well, I thank you for that. And I think I echo Dr. Roe, and probably Dr. Wenstrup who will probably come up on this, this physician leadership piece, I really have buy-in on that. And again, I am somewhat biased that Mayo Clinic plucks their leadership from their physicians and that rotates through, and that has proven to be a successful model.

I yield back.

The CHAIRMAN. Thank you.

Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

I want to thank both of you, and I would like to thank the entire team that worked on this. It was not just you two, as you will acknowledge, as you are shaking your head.

Obviously, our goal was to provide care for those in need for our veterans, and one of the things that I have seen that assures our veteran patients as much as anything else is having a primary care doctor they call their own. That is one of the successes that I see at the CBOCs. What I do not like is the stigma sometimes that any doctor that is not within those walls is a non-VA doctor, and I think we need to change that stigma. They are VA doctors just as much as anyone else, that they are part of a system and Dr. Roe referred to that.

And when it comes to choice, I think we need to embrace greater choice, because the decisions on referrals and choices should come between the primary care doctor and the patient, and we don't need another layer of bureaucracy of people that don't know the doctor or the patient that decide who you get to go to, where and when, because as you know, making a referral is based on many things and knowing your patient. It has to do with personalities sometimes, it has to do with the level of expertise, it has to do with comorbidities and the severity of those comorbidities, and there is no panel that can embrace that; only the primary care doctor and the patient can embrace that. And that is the type of system I think we need, because if I was a patient in that system I would

be saying, Doctor, are you referring me to this person because you have to, or because it is the best fit for me? And that is what we have to open our minds to is having that capability.

And then it comes to reality, we have got to know the cost and efficiencies of what is taking place. I have said since the day I got here almost four years ago, how much are you spending per RVU you are producing, do you have any idea? And to this day, I still haven't gotten that answer. We did have one independent survey here and I think Dr. Abraham will attest to this. They said that for a primary care visit it was between four and \$600. Well, you can make a pretty good living on the outside at four to \$600 per patient visit.

So obviously we have got to be able to have that type of data to make our decisions, because certainly, let's use the example of say an organ-transplant team, not every VA should have or can have an organ-transplant team. So you have to have one within the VHA system that people can refer to, because that is the most efficient, the most effective and the best care.

So we have heard a lot today. I am getting to a question and that is, where do we need to go as far as next moves? And I think we all kind of, would agree that the electronic record is a first move, and along with that, the decision on how we go about handling a board of directors, constitutionally or otherwise. So beyond those two, what would you say would be the next move where we can weigh in and have some impact on the next move in bettering our situation?

Ms. SCHLICHTING. We may have different points of view on this, but I would say the personnel system itself. Because one of the critical elements is attracting talent and there is still a lot of openings within the VA system in all types of jobs, whether it is, you know, leadership or front line or physicians, and I think that looking at how to create a more organized system that ensures that in all positions there is an ability to attract that talent.

And I actually think that with that, the VA would do a much better job attracting talent across the country, because there are many people, including some at Henry Ford, that have gone to work for the VA because they want to help veterans, and I think if they felt that that system were more efficient and effective, they would be there.

Mr. WENSTRUP. Doctor?

Dr. COSGROVE. Yes, I think you clearly need that, but I think ultimately, at the end of the day, culture is the main thing that makes any organization work. It is all about people, it is not about bricks and mortar. And changing the culture, that is going to require sustainability of the leadership and a sustained push at changing the culture of the organization.

And, you know, the focus clearly has to be on the patient, the veteran, and how are you going to do the best thing for the veteran and everything will flow from that. That is your North Star, that is your *raison d'etat*, and everybody in the organization needs to understand that from the get-go.

Mr. WENSTRUP. And I appreciate the comments on provider input in how we go about conducting the business of taking care of people.

Thank you. I yield back.

The CHAIRMAN. Thank you very much.

Mr. Takano, you are recognized for a second round.

Mr. TAKANO. Thank you, Mr. Chairman.

Did the Commission look at all about the difficulty of the VA being able to hire military doctors in the VA? Are there any complications or things that we can do to—I have heard there are some issues related to that.

Dr. COSGROVE. I am not sure. You have to tell us what the issues are.

Ms. SCHLICHTING. Yeah, I am not.

Mr. TAKANO. I was just—apparently you don't have an answer to the question, but I just wanted to pose it.

The other thing, is I wanted just to make mention, and I thank my colleague Mr. O'Rourke for bringing up the medical residencies and we have increased them. My understanding is the VA has not been able to assign all of them, only 300 out of the 1500, and I just want to take a moment to make an appeal to my Republican doctor colleagues to address the Medicare cap and the time extensions. I would hate to lose those because the clock is running out.

One issue that has come up over and over again is the way that—our VSO testimony is their concerns regarding private sector metrics. The VA has testified many times that the private sector does not measure things that are important to veterans' health care. How did the Commission envision the VA adopting private sector measures if the private sector does not measure them, in terms of that there are some things that the private sector doesn't measure?

Ms. SCHLICHTING. Can you give an example?

Mr. TAKANO. There are specific things that may be unique to what the VA does as far as what veterans do.

Ms. SCHLICHTING. You know, we—

Mr. TAKANO. Mental health comorbidity as an example.

Ms. SCHLICHTING. Well, those issues exist in the private sector as well, and we have a very large behavioral health population at Henry Ford, and worked on initiatives such as perfect depression care where we have tried to reduce the level of suicide to zero for a managed population. And, you know, while the background and issues might be somewhat unique, the comorbidity problem exists.

And so, you know, we have to constantly drive toward results even when we have those conditions, whether it is socioeconomic risk, or it is other health factors and combat experience that affect people. So I think there is a way to work toward that set of metrics that could be very comparable.

Dr. COSGROVE. We are looking at the same sort of things. We are looking at socioeconomic determinants, mental health determinants, as well as physical determinants.

Mr. TAKANO. But here is the thing: are they truly comparable? I know you do these metrics, but are—

Ms. SCHLICHTING. Well, the one thing I will tell you, being in Detroit, is we live in a world of trying to always have reasons why our data looks worse and we try not to have those excuses, that we clearly believe there are strategies to improve care even when we have a tough socioeconomic group of people with poor health condi-

tions. We serve, as many organizations do, a lot of veterans that don't seek care within the VA.

And so I think we have got to really drive toward those kinds of metrics that push us in a direction of much higher performance.

Mr. TAKANO. Comparing the VA to private sector care is not always a fair comparison. For instance, the VA must adhere to Federal hiring and firing practices that allow for fair treatment and due process. I heard you engage with one of the other Members and I was delighted to hear that you believe that a central problem is leadership, training and follow-through, making sure there is progressive discipline, and that a lot of these personnel procedures exist in the private sector care as well.

And I might have you elaborate more on what you said before, because accountability is one of the things this Committee is struggling with.

Ms. SCHLICHTING. Well, you know, it is very easy in a health care environment to find reasons why people don't perform, it just is, and often there is a pattern of making excuses for people. And it is critical that we push on that level of accountability and performance in all positions: front-line staff, physicians, nurses, leaders. And I think that is part of the culture that Toby and I have talked about today is creating that sense that you have to perform at a high level, and that in fact you are going to follow through on making sure that if people aren't doing that, that there are consequences.

Dr. COSGROVE. And I would just add to that. Any time I have found a problem, regardless if it is on a nursing floor or in a hospital, it goes right back to leadership. You change the leadership, you put a better leader in, you get better performance. I can't stress too much the importance of leadership.

Mr. TAKANO. And investing in the training and—

Ms. SCHLICHTING. Absolutely.

Mr. TAKANO. And you believe it is possible for there to be accountability, that we can improve accountability at the VA?

Ms. SCHLICHTING. Yes.

Dr. COSGROVE. There has to be accountability. I mean, do you not have accountability when you get voted on every year—every other year?

Mr. TAKANO. But in other words, you don't do away with due process, that due process has to be a part of that accountability system, but leadership has to work with that due process.

Ms. SCHLICHTING. Let me make a comment, though. I do think human resources as a division within VA is undervalued and under-invested in, from my vantage point, in terms of the quality and the experience of HR leadership, because it really takes strong leadership on the HR side to really put those processes systems in place to make sure that people are following them. And when we talked with some of the HR leaders, we did not get the sense that that was the tradition of the VA system to have that level of leadership.

Dr. COSGROVE. And I would completely second that. It was embarrassing to hear the level of HR activities at the VA.

Mr. TAKANO. So perhaps rather than focusing in on the due process procedures and all of that, I mean, there is some value in that,

but focusing on the investment in HR would be a worthwhile thing for this Committee to look at.

Ms. SCHLICHTING. Yes.

Mr. TAKANO. Great. Thank you.

The CHAIRMAN. Thank you.

Dr. Abraham, you are recognized.

Mr. ABRAHAM. Thank you, Mr. Chairman.

Just a quick comment. Phenomenal work, and you bring to this Committee that we as the Committee expect and the taxpayers expect and that is credibility. The way I understand the math, you guys command \$13 billion of revenue between both clinics and that has done successfully. So you are the experts in the room on managing health care.

On the choice, certainly we are all fortunate on the Committee here to have thousands of veterans in our districts, and we realize how important we are to represent them and how fortunate we are. I am a big advocate of choice and the arguments I have heard against it as far as expanding the distance or taking away the obstacles is that it would weaken the VA system simply because you could possibly have a migration of patients. In my opinion, I think it would actually strengthen the VA system. If it makes them more competitive, things get better with competition.

And, Doc, just going back to your comment, I have worked with EMRs such as all the three physicians on my right have. You said the Cleveland Clinic reports up to 100 quality metrics. You and I both know that those metrics could be reported just like that with an EMR because they are entered into the database.

Dr. COSGROVE. Yes.

Mr. ABRAHAM. So that answers the question of quality metric measurement right there. So, you know, it is a huge thing to get EMRs in place, they work, and again we need to do it commercially. The way you eat a whale is one bite at a time. And of those four things that you highlighted in your testimony, the EMRs and the supply chain. Hopefully the VA is leveraging their volume of catheters, name whatever, trach tubes, you just name, but if they are not, you guys, I think you said you save like \$274 million over a period of time. If the VA is not doing that, then, wow, shame on them for not getting in the game long ago, because they order millions of quantities of supplies probably on a quarterly basis.

Dr. COSGROVE. Yes.

Mr. ABRAHAM. So do you have a comment on that, Doc?

Dr. COSGROVE. Yes. I think one of the other things I emphasized is that particularly for physician choice issues like pacemakers or artificial knees or hips, to get the physicians involved and then you can drive down to a couple of choices and then you can drive the price down with the providers of those pieces of equipment, and that is where we have had major savings.

Mr. ABRAHAM. It is just good business.

Ms. SCHLICHTING. You know, interestingly, the VA does a terrific job on drug purchases.

Dr. COSGROVE. Yes, they do.

Mr. ABRAHAM. Why not on supplies?

Ms. SCHLICHTING. So it was surprising to us to see that they weren't providing, you know, the same type of approach on the non-drug medical supplies.

Mr. ABRAHAM. Well, again, thanks for your work, we appreciate it.

And I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mrs. Radewagen, you are recognized.

Mrs. RADEWAGEN. Thank you, Mr. Chairman.

I too want to welcome you both and thank you for your leadership and service.

Ms. Schlichting, in my home district, American Samoa, over 60 percent of the veterans have to travel off-island at a minimum of five hours by air for medical appointments. In the Commission's final report as part of the commissioner site visit observations, the report cites poor access to VA care for rural veterans as one of the major weaknesses of the VA. For instance, in American Samoa, the hospital is in such need of upgrades to facilities and equipment, as well as being short-staffed, that the VA drastically limits the use of the hospital for VA health care.

Were the U.S. insular areas included in this evaluation as part of the under-served and/or rural areas? And would you please highlight which of the Commission's recommendations are aimed to address these under-served areas, especially those you think would apply to the U.S. insular territories?

Ms. SCHLICHTING. You know, to be candid, we did not spend time on the specific issues that your place of origin really has. But on the other hand, we did pay a lot of attention to the issues of rural access and really thinking about how to provide improved access. This was one of the reasons we thought it was so critical to really look at a more integrated model of care, because in many parts of our country and beyond we have situations where veterans simply cannot get the access they need locally through the VA, but in fact are using in some cases private health care, but perhaps not organizing it as well. And the organization is actually very critical to the outcomes of care, care coordination and making sure people have the kind of providers that they need.

So what we recommended was this integrated model of creating one system, so that in every part of, you know, where veterans live and work that they have access to what they need in a way that really enhances their outcomes, but we did not look at that specifically.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Mr. Takano, any other questions?

Mr. TAKANO. I have no questions and neither do any of the other Members.

The CHAIRMAN. Okay. Thank you very much.

I have one other quick question, it kind of piggybacks on what Mr. Takano was asking about training and my question is, we all agree that due process is very important, my question is should it take a year or longer to discipline an employee or to fire them?

Ms. SCHLICHTING. Well, you know, the way I look at that is it depends on the situation that they are dealing with. In most cases,

you know, due process is much more efficient than that, but if someone has a serious issue that has appeals built in, sometimes time has a way of, you know, increasing. But I think the key is measuring is the process efficiently operating, and those are things that should be evaluated to really determine whether that timing makes sense or not.

The CHAIRMAN. Dr. Cosgrove?

Dr. COSGROVE. Yes, I agree. You know, for example, as a physician we do annual reviews of everybody at the Cleveland Clinic, including physicians, and we do not just fire someone unless it is something terribly egregious without having gone through the due process over a period of time. Sometimes that is more than a year of collecting a physician's information, but depending upon the—we have fired some people on the spot for egregious things that have occurred.

The CHAIRMAN. All right, thank you very much.

Also I would like to again thank the ten Veterans Service Organizations that did in fact provide written testimony for today. It is a very important part of the record, as is the written testimony that VA provided as well.

Again, I think you heard from every Member of this Committee a great appreciation of the time and the effort that you and all Commission members did provide. The document is very important for us, for transforming a department that is in need of serious transformation into the 21st century.

And I would say that all Members would have five legislative days with which to revise and extend or add any extraneous material regarding this hearing.

Without objection, so ordered.

And with that, this hearing is adjourned.

[Whereupon, at 12:44 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Nancy Schlichting

Chairman Miller, Ranking Member Takano, and Members of the Committee:

I am pleased to appear this morning to discuss the workings, deliberations, findings, and recommendations of the Commission on Care, which I was privileged to chair. And I am delighted to be accompanied by my colleague, Dr. Delos (Toby) Cosgrove, the Commission Vice Chairperson, and the Chief Executive Officer (CEO) of the Cleveland Clinic. I also want to take this opportunity to thank you for your support of the Commission, and your assistance in providing us an extension of time to complete our work.

For the last 13 years, I have served as the CEO of the Henry Ford Health System (Henry Ford), a Detroit-based \$5 billion, 27,000-employee organization, which I joined after many years of senior-level executive positions in health care administration. I believe my experience in leading Henry Ford through a dramatic turnaround of its finances and culture and in winning a Malcolm Baldrige National Quality Award and national awards for customer service, patient safety, and diversity initiatives played a role in the President's selecting me to chair this important body. I accepted this position not only because I was honored to be selected, but because I hoped that this commission could make a difference. I believe our report offers that promise.

As you well know, Mr. Chairman, just a little more than two years ago, Congress and the Administration faced a real crisis of confidence in a health system some had once seen as providing the best care anywhere. In 2014, alarming delays in providing needed care, and the scandal surrounding deceptive reporting on patient-scheduling, led to the enactment of a far-reaching omnibus law that established the Commission on Care.

Congress is to be commended for including in that law provisions that commissioned an independent assessment of VA health delivery and that charged our commission to assess access to care and critical strategic issues. I was privileged to work with a group of commissioners who brought a diverse, rich breadth of experiences and perspectives while sharing a strong commitment to our veterans.

The Commission's Veteran-Centered Approach

The Independent Assessment, released in September 2015, was invaluable in providing the Commission a comprehensive, carefully-researched, system-focused analysis that both informed our work and provided an invaluable integrated framework for our examination and deliberations.

As we explained in our interim report, early on the Commission adopted a set of principles to guide our work; that identified both how we would proceed and the core values we would honor. Our adherence to those principles proved critical, in my view, to the development of a final report that is value-based and centered on our veterans.

While each of those principles was meaningful and important to our work, let me highlight just a few I think are particularly relevant to our dialogue this morning:

- The deliberations and recommendations of the Commission will be data-driven and decided by consensus.
- The Commission will focus on ensuring eligible veterans receive health care that offers optimal quality, access, and choice.
- Recommendations will be actionable and sustainable, focusing on creating clarity of purpose for VA health care, building a strong leadership/governance structure, investing in infrastructure, and ensuring transparency of performance.

I believe you will find that these core principles profoundly influenced and are deeply embedded in the content of our final report.

Our work over a ten-month period—including 12 deliberative and educational meetings over the course of 26 days—was not easy. Our public hearings were wide-ranging; our discussions were frank. Through testimony and dialogue, the Commission considered the broadest span of perspectives we could assemble: these included senior VA leaders and VA program and subject-matter experts; stakeholders, including representatives of national veterans service organizations, union and association leaders representing Veterans Health Administration (VHA) employees, individual veterans, Choice Program contractors, representatives of medical school affiliates and associations of behavioral health care professionals; former VHA Under Secretaries of Health and VHA network and medical center administrators; experts in health care and health care economics; and members of this Committee. Our Commission, with its diverse membership, had spirited discussions, debates, and sometimes difficult deliberations - perhaps not unlike the process that leads to good legislation. Importantly, too, those deliberations were conducted in public sessions, in a process which was stronger for its transparency. Like your own work on this Committee, we were focused on and bound together by the unifying question, “What’s best for the veteran?” I believe we have been true to that challenge, and that our report provides actionable, sustainable recommendations - many of which invite congressional action.

Importantly, we discussed at length the challenge of determining what veterans themselves want. To what, we asked, could we look to find the “voice of the veteran?” Time constraints and regulatory requirements ruled out conducting a Commission survey of veterans. But we pursued multiple other avenues and sources to tap and ascertain veterans’ views, certainly including your advice, Mr. Chairman, that we engage the veterans’ service organizations, who participated fully in our work.

Status of VA Health Care Delivery System and Management Processes

In its sweeping report, the Independent Assessment identified troubling weaknesses and limitations in key VA systems needed to support its health care delivery. Reaching very similar findings, the Commission concluded that—if left unaddressed—problems with staffing, facilities, capital needs, information systems, procurement and health disparities threaten the long-term viability of VA care. Importantly, though, neither the Independent Assessment nor our review called into question the clinical quality of VA care. Quite the contrary. The evidence shows that care delivered by VA is in many ways comparable to or better in clinical quality than that generally available in the private sector.¹ This is a testament to the high quality of its clinical workforce.

Yet we found a system that faces many grave problems: high among them, an ongoing leadership crisis, confusion about strategic direction, significant variation in performance across the VA health system, and a culture of risk aversion and distrust. Despite the various deep problems facing VHA, our report does not propose shuttering the system or placing its future at risk.

With our focus on what is best for the veteran, the commissioners recognized that the VA health care system has invaluable strengths. It is an integrated health care system with a compelling mission that combines care-delivery, educating health professionals, conducting research, and carrying out a contingency national-emergency mission. VHA has developed and operates unique, exceptional clinical programs and services tailored to the needs of millions of veterans who turn to it for care. For example, its behavioral health programs, particularly their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered the effects of battle or military sexual trauma, or for whom VHA is a safety net. VHA’s “wraparound” case-management services meet the most vulnerable veterans where they are to prevent them from falling through the cracks. As the largest national health care system, VHA continues to have the capacity to bring about reforms in the larger health care industry. By way of example, it pioneered bar-coding of pharmaceutical drugs, and championed improvements to patient-safety through systematic identification and review to identify root causes of medical mistakes and “near misses.” In working to close access gaps, VA has developed one of the largest telehealth and connected-care operations in the world. While VHA can learn from private sector care, we also benefit from its successes.

¹ VA care has often been cited to be as good as or better than that of private sector. The following paper, identifying about 60 studies by disease type, supports that statement. <http://avapl.org/advocacy/pubs/FACT%20sheet%20literature%20review%20of%20VA%20vs%20Community%20Health%20Care%2003%2023-16.pdf>

Transformation

We are clear, however, in our view that VHA must change, and change profoundly, because veterans deserve a better organized, high-performing health care system. Certainly, some elements of such a high-performing system are already in place. VA has high-quality clinical staff, and this integrated health care system is marked by good care-coordination. VHA today, however, relies significantly on community providers to augment the care it provides directly, although those community partners are not part of a cohesive system. VA and VHA are already undergoing substantial change under the leadership of Secretary Robert McDonald, Deputy Secretary Sloan Gibson, and Under Secretary for Health David Shulkin, and it is important to recognize and encourage this change process.

All of our commissioners agreed on the need to transform VA health care. At the heart of that transformation, we call for VA to establish high-performing health care networks that include and that integrate the care provided by credentialed community-based clinicians along with VHA and other federal providers, and that afford veterans primary care provider-choice, without regard to criteria like distance or wait times. The establishment of integrated care networks - what we refer to in the report as a new VHA Care System - is nothing less than a fundamental change in the model of VA care-delivery. It is a model that will much more closely integrate VHA with its community partners, with an emphasis on coordination of care that is so important to the population VHA serves, one with more chronic illness and behavioral health conditions than the general medical population. High quality care is a critical element, so we propose that VA control network design; set high standards for community-provider participation, to include a credentialing, quality and utilization performance, and military/cultural competence; and tightly manage the networks. Our vision for this transformed system is one that would offer major improvements: improved access to care, care-quality, and choice, with resultant improvement in patient well-being.

Such a system, which Dr. Cosgrove and I would be happy to discuss in more detail, would provide our veterans with the high quality health care they richly deserve. But successful implementation of that recommendation is not only contingent on legislative action but, as importantly, on adoption of other major inter-dependent initiatives proposed in our report. In short, our report - as well as the Independent Assessment - makes very clear that providing veterans access to needed care cannot be achieved by "tweaking" existing programs or mounting a complex new delivery framework on a weak infrastructure platform. Rather, it requires an integrated systems approach that not only redesigns VA's health care delivery system, but re-engineers fundamental internal systems. Transformation will require streamlining key functions such as IT, HR, procurement, facilities-management; investing in IT and facilities; building a strong leadership system; strengthening VHA governance; and reorganizing the relationship between VHA leadership and the field. Clearly, it will take time and will require relentless commitment by all stakeholders.

Let me add that in recommending a transformation of VA health care delivery and the systems that underlie it, we used the term "transformation" advisedly to mean fundamental, dramatic change - change that requires new direction, new investment, and profound re-engineering. Virtually all the commissioners agreed our recommendations are bold, though you have, no doubt, heard isolated voices of disagreement. One view disputes our belief that our report's recommendations would be truly transformative, and says instead that the report proposes only limited reforms and will do little to redirect veterans' health care. At the same time, our work has also been characterized as a "horrendous, anti-veteran proposal." Both critiques widely miss the mark, in my view. Our focus, however, was not on how our recommendations would be characterized, but with developing a report that would result in meaningful improvement in veterans' care. I believe we have laid that foundation.

"Privatization"

It is no secret that the Commission debated the merits of so-called "privatization" or of veterans being offered unfettered choice from among all Medicare-qualified providers. It is also no secret that some among the membership are deeply skeptical of government-run health care, and some believe current trends will ultimately lead VA to a payer only role. Regarding the 20-year horizon to which the Commission was to look, though, we can foresee continued dynamic change in health care. Already, there has been a dramatic increase in outpatient care. We can also speak with some confidence about the potential for explosive growth of telemedicine, increasing emphasis on preventive care, the introduction of precision medicine and the likely proliferation of technologies that permit routine home-based health moni-

toring of patients with chronic illnesses. But we're also in agreement that the rapid changes overtaking health care make it impossible to accurately forecast further than five years out.

While we cannot fully foresee the medical breakthroughs of the next decades, the Commission did acknowledge important realities:

- Despite profound challenges it must overcome, the VA health system is important to millions of veterans and has great value in providing clinical care, educating health professionals, conducting research, and carrying out a contingency national-emergency mission.
- Millions of veterans will continue to need care in the future that VA provides through critical programs and special competencies that are either unique or of higher quality or greater scope than is available in the private sector.
- Many veterans have complex medical and well-being needs, often greater than are commonly present in the general population.
- As a result, in considering the option of VHA becoming solely a payer, one must acknowledge that health care systems and facilities across this country are generally not equipped to meet many of the unique and complex health needs among the roughly six million veterans whom VA treats annually, particularly those with the highest priority in law: the service-connected disabled and those with limited financial means.
- The difficulties veterans have experienced in accessing timely care in the VA health care system are also relatively common experiences among health care consumers outside VA where national shortages of primary care physicians, psychiatrists, and certain specialists are everyday problems.
- Finally, many private health care systems have not established programs to fully coordinate care - an important attribute of VA-provided care.

This last point has particular relevance to the idea that veterans would be better served if they were simply provided a card or care-voucher that entitle them to get care virtually anywhere at VA expense. That strategy would surely lead to more fragmented care. As described by one highly acclaimed former Under Secretary for Health-

“Fragmentation of care is of concern because it diminishes continuity and coordination of care resulting in more emergency department use, hospitalizations, diagnostic interventions, and adverse events. The VA serves an especially large number of persons with chronic medical conditions or behavioral health diagnoses - populations especially vulnerable to untoward consequences resulting from fragmented care.”²

Needed Congressional Action

Importantly, our recommendations highlight the critical role we see for Congress. The Commission certainly recognizes that veterans' access to care has long been a high congressional priority. Congress has strengthened the foundation of care-delivery through legislation, provided needed medical-care funding, and conducted important oversight. In creating our Commission, you asked the important question, how can the Nation best deliver veterans' care in the years ahead? Let me highlight some of the critical steps we recommend Congress take:

- Provide VA needed authority to establish integrated care networks through which enrolled veterans could elect to receive needed care from among credentialed providers without regard to geographic distance or wait time criteria;
- Address fundamental weaknesses in VHA governance;
- Provide VA more flexibility in meeting its capital asset and other needs, including -
 - (1) Establishing a capital asset realignment process modeled on the DoD BRAC process;
 - (2) Waiving or suspending the authorization and scorekeeping requirements governing major VA medical facility leases;
 - (3) Lifting the statutory threshold of what constitutes a VA major medical facility project;
 - (4) Reinstating broad authority for VHA to enter into enhanced-use leases; and

² Kenneth W. Kizer, MD, MPH, “Veterans and the Affordable Care Act,” JAMA, vol. 307, no. 8 (Feb. 22/29, 2012) accessed at https://commissiononcare.sites.usa.gov/files/2016/01/20151116-02-Veterans_and_the_Affordable_Care_Act_JAMA_Feb2012_Vol307-No8.pdf

(5)Easing, for a time-limited period, otherwise applicable constraints on divestiture of unused VHA buildings.

(6)Establishing a line item for VHA IT funding and authorize advanced appropriations for that account.

- Create a single personnel system for all VHA employees to meet the unique staffing needs of a health care system; and
- Invest in needed VHA IT funding and facilities.

I'd be happy to discuss any of these in more detail, but let me amplify one point, which our commissioners viewed as foundational. The Commission saw VHA's governance structure as ill-equipped to carry out successfully the kind of transformation required to re-invigorate this health system, which all agreed would be a multi-year process. Continuity of leadership and long-term strategic vision—critical both to implementing a transformation and to sustaining it - cannot be assured under a governance framework marked by relatively frequent turnover of senior leadership and near-constant focus on immediate operational issues. The Commission believed that two fundamental governance changes were needed: establishment of a board of directors with authority to direct the transformation process and set long-term strategy, and change in the process for the appointment for and tenure of the official currently designated as the Under Secretary for Health. Of course, I'd be happy to discuss these and other recommendations in more detail.

Cost

Let me emphasize that the Commission's aim was to develop recommendations that are actionable, sustainable, and would realize the vision of improving veterans' access, quality of care, choice, and well-being. We did not set out with the preconceived notion that bold transformational change was needed. Rather we stayed true to our guiding principles and to where our findings led us. Also, we were not constrained by cost considerations, though we did recognize early that the U.S. taxpayer is one of the Commission's stakeholders and we worked with health economists to model different options. Our report includes an appendix chapter that presents estimates of the cost of alternative policy proposals.

We recognized that our recommended option for expanding community care through the establishment of integrated care networks would result in higher utilization of VA-covered health care and, accordingly, in additional costs, in the view of our economists. But we believe adoption of other Commission recommendations and options discussed in our report can help mitigate the increased costs. Projecting costs, as you know, includes elements of uncertainty. Our economists could not estimate savings or costs that might result from reducing infrastructure, for example. Similarly, they could not assign costs to needed investment in IT and facilities.

Implicit in our discussions, though, has been the question - should the Nation invest further in the VA health care system? Our report answers that question in the affirmative, even as it underscores the need for sweeping change in that system. We do not suggest that Congress has not already made very substantial investments in the system. Rather we call for strategic investments in a much more streamlined system that aligns VA care with the community.

In my judgment, our report points the way to meeting the central challenge Congress identified in 2014: improved access to care, while offering a vision that would expand choice, improve care-quality, and contribute to improved patient well-being. It is a vision that puts veterans first, not an approach crafted to win buy-in from system administrators or other interests. My long experience tells me that that veteran-centered focus will ultimately improve the service veterans receive while strengthening the system and providing increased transparency and accountability. In my view, this is a vision that merits your support.

I would be pleased to be a resource to this Committee as you continue to work on these issues. I would also be happy to respond to your questions.

Prepared Statement of Delos M. (Toby) Cosgrove, MD

Chairman Miller, Ranking Member Takano, and Members of the Committee, thank you for inviting me to speak about the Commission on Care Final Report today.

As a former Air Force surgeon, I care deeply about the welfare of the Nation's veterans and I have been honored to serve as vice chairperson of the Commission on Care and as a member of the MyVA Advisory Committee. Over the course of my work with the VA, I have become well-acquainted with the Department and under-

stand its contributions as well as its challenges in meeting our veterans' needs. As CEO of Cleveland Clinic, an \$8 billion dollar health care system serving communities across the country and internationally, I'm keenly aware of the magnitude of the challenges facing VA health care leaders. Mr. Chairman, the veterans' health care system must make transformative changes to meet the health care needs of veterans today and tomorrow. If these changes are not made, the VHA's many systemic problems threaten the long-term viability of VA care.

The final report contained eighteen (18) different recommendations. Today, I am going to address four specific areas that include; the establishment of integrated community-based health care networks, quality metrics, information technology (specifically electronic health records), and supply chain.

Given the Commission's charge to examine veterans' access to care, it was concluded early on that greater reliance on, and closer integration with, private sector care held the greatest promise for improving not only access, but affording veterans greater choice. As you know, the Commission considered and debated options that would provide for different degrees of choice. The recommended option in the Commission's Final Report reflects a consensus position, though many supported an option that would provide veterans still greater choice of private sector providers. The Commission agreed that the VHA must establish high-performing, integrated, community-based health care networks to provide timely and quality care to our veterans.

The report envisions a continued role for a VHA health care system, but as we said - if the challenges and opportunities described in the final report are left unaddressed we are concerned that our veterans will not receive the kind of high-quality care that they deserve. Among our proposals, the Commission recommends that VHA adopt a continuous improvement methodology such as Lean Six Sigma to engage staff and improve the culture. This will help, but it will also take significant investments in time, effort, and resources to modernize and streamline such essential functions as human capital management, capital asset management and leasing, business processes, and information technology.

The Commission recommended that the VHA should implement core metrics that are identical to those used in the private sector. Veterans deserve to know that the health care they are receiving either from VHA or from a community provider is of high-quality. If these metrics are put into place, it will be easier to evaluate the system's performance and Congress will have benchmarks from the private sector to compare both its progress and the improvement over time. Congress and the American people deserve to know that VHA is getting value for their investment.

Years ago, the VHA was a leader in the field of electronic health records. Unfortunately, this is no longer the case. Therefore, the Commission believes that the VHA should transition to the same type of commercial off-the-shelf electronic health records as other providers. By using a proven product, many of the scheduling and billing problems would be resolved. Further, these systems could help the VA identify areas for opportunity and utilization to promote better access to care for our Veterans and promote interoperability which is critical as veterans move to different care sites. Finally, the commercial EHR would also allow VHA to link financial and clinical information-a critical functionality for running modern health care delivery systems. The best and most prevalent commercial EHR programs allow staff and patients to schedule patient care easily and to provide legitimate performance measures for wait times, unit costs, clinical care outcomes and productivity that conform to those of the rest of the health care industry. Many of our country's best hospital systems have converted homegrown information systems to commercially-based systems. VHA must do the same to remain current and engage with the rest of the health care system. It must also have its own leadership-specifically a chief information officer for VHA information systems that allows VHA to adjust its information needs as the health care industry evolves.

As a VHA contractor, Cleveland Clinic has experienced first-hand the burdensome, antiquated system that is currently in place to receive payment. We are required to provide documentation in hard copy form sent via the postal services as they will not accept either fax, email or any other electronic submission. If a request results in more than 100 pages we must burn the records to a disc. Because we do not have any mechanism to track whether the documentation has been received, we have heard on many occasions that they "never received the paper records" and we have no recourse other than to send them again. The Independent Assessment that Congress commissioned found that VHA should keep claims adjudication and payment separate from its care delivery. The health care system that the Commission envisions for VHA will continue to expect exceptional performance from its network of providers and providers should expect timely and accurate payment in return.

Supply chain is another area ripe for VHA streamlining. The Commission's report stated that the "purchasing processes are cumbersome which has driven VA staff to workarounds and exacerbates the variation in process the VA pays for products." The VA should consolidate and reorganize the procurement and logistics for medical and surgical supplies under one leader. The VHA has enough market share to leverage prices that could result in savings of hundreds of millions of dollars.

At Cleveland Clinic, we are constantly evaluating and reviewing our supply chain products and processes. Today, our Supply Chain is working with teams of clinicians led by physician champions to justify purchases of more expensive supplies by engaging clinical staff in a value-based sourcing effort that illustrates that cost and quality do not have to be mutually exclusive principles. Clinicians are made aware of the costs and outcomes associated with different brands. Once the clinical staff has to justify the higher costs and understands whether they add value to care outcomes based on empirical evidence, they make purchasing decisions based on value. Such efforts are then integrated into patient-centric utilization management and inventory management efforts to ensure the appropriate use of our resources. A clinician-engaged, value-based supply chain management practice model has allowed us to save \$274 million dollars over the last six years. We are continuing to reform our processes by entering into purchasing consortia with other nonprofit health care providers and ensuring that we are continually searching for improvements in cost management.

Of course, leadership is the key to transformative change. The Commission speaks to the need to create a pipeline for internal leaders and to make it easier for private sector and military clinical and administrative leaders to serve in VHA. Market-based pay is critical to bringing in leaders capable of taking VHA to the next level. The Commission also proposes that Congress provide for a VHA governance board to provide a long-term strategic vision and successfully drive the transformation process. Both the chairperson and I will be happy to talk more about this aspect of the report.

Mr. Chairman, transforming a system as large and complex as VHA's will require streamlining multiple systems, redesigning care-delivery, and more. This report offers a roadmap to success. Realizing the vision the report proposes will require new investment, (both financial and in expertise), enactment of legislation, and strong leadership.

Thank you for your attention. I am happy to address any questions you may have.

Statements For The Record

THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Chairman Miller and Ranking Member Takano:

The American Federation of Government Employees, AFL-CIO and its National VA Council (AFGE) thank the Committee for the opportunity to share our views regarding the final recommendations of the Commission on Care. AFGE represents nearly 700,000 federal employees including more than 230,000 employees of the Department of Veterans Affairs (VA). Within the Veterans Health Administration (VHA), AFGE represents employees at nearly every medical center and is by far the largest representative of medical and mental health professionals and support personnel.

Overview

Although the Commission did not formally adopt the controversial "strawman" proposal, the impact would be very similar. Both would dismantle our veterans' only specialized integrated health care system and incur unsustainable costs that will inevitably lead to lower quality care and fewer health care services for fewer veterans.

Both would also destroy veterans' true source of "community care": care provided within the Veterans Health Administration (VHA) that is closely coordinated with VA vet centers and Veterans Benefits Administration (VBA) benefits and employment services. The Commission's description of non-VA care as "community care" is a misnomer. Veterans strongly prefer to receive their care from the VA over the private sector according to the Vet Voice Foundation poll and other recent polls.

The Commission recommendation (#15) to eliminate all civil service protections under Title 5 would increase retaliation against employees who report mismanagement and take veterans' preference rights away from thousands of veterans who choose VHA careers. The loss of seniority-based pay under the Commission's proposed new Title 38 personnel system would severely weaken the VA's ability to re-

tain experienced providers. The proposed elimination of Title 5 due process protections and Merit Systems Protection Board appeal rights would allow managers to hire and promote based on favoritism and political affiliation instead of merit.

As the Committee contemplates the future of the VA health care system, AFGE also strongly urges the Committee to save our treasured health care system from “death by a thousand cuts.” VA health care is already being dismantled “brick by brick” through the closures of many emergency rooms, intensive care units and other essential medical units. AFGE is also very concerned about the impact of VHA’s overreliance on contractor-run outpatient clinics on quality of care, care coordination and costs and the secretive process for issuing and renewing these contracts. The most recent stealth attack on VHA is the imminent replacement of nearly all VHA compensation and pension (C&P) disability exams with contractor exams without any apparent analysis of the impact on veterans’ disability ratings, access to integrated VHA care or costs.

Recommendations #1 and #9: AFGE vehemently opposes Commission recommendations that would result in a massive shift of VA care to the private sector through unrestricted access to non-VA primary and specialty care and the transfer of primary control over veterans’ care from the Secretary to an unelected corporate-style board running a new VHA Care System. AFGE concurs with Commissioner Michael Blecker that these drastic changes would result in “the degradation or atrophy” of critical veterans’ health services. VA would also lose the critical core capacity that has enabled it to be the Nation’s leading source of medical training and cutting edge research. Our nation would also lose the critical assistance that the VA provides through its “fourth mission” during national emergencies and natural disasters, from Hurricane Katrina to the Orlando mass shooting.

VHA must remain the primary source of veterans’ care, the exclusive provider of primary care and the exclusive care coordinator. VHA must retain control over the design and oversight of local, integrated care networks. AFGE fully supports the proposal for local integrated care networks developed by the Independent Budget veterans’ service organizations and the similar proposal included in the VA’s Plan to Consolidate Community Care.

Putting a private governance board at the helm would also vastly reduce the ability of Congress and veterans to hold wrongdoers accountable for mismanagement, corruption and patient harm. The Commission acknowledged that the board would not have to comply with the open government requirements of the Federal Advisory Committee Act and most likely would not be subject to the Freedom of Information Act.

Recommendation #2: The Commission’s proposal to relieve the Secretary of the requirement under the Millennium Act to report annually to Congress on the number of beds closed the previous year constitutes another unjustified assault on accountability. AFGE agrees that current bed count data is inadequate but the solution is not less data. We have repeatedly sought Congressional oversight of “bed count gaming” where managers manipulate bed count data to hide the number of actual beds available to veterans. When beds are closed (primarily due to management’s unwillingness to hire sufficient nurses), veterans are sent to non-VA hospitals that are less equipped to treat their unique conditions, often imposing greater costs on veterans and taxpayers.

If the bed count reporting requirement is eliminated, thousands of veterans’ beds will be lost forever, staff will be laid off, and smaller facilities may not survive. VA beds have also played a critical role in our national disaster response plan; during Hurricane Katrina, patients were moved to VA medical centers in Houston and other locations. Therefore, we urge the Committee to reject this recommendation and instead, conduct oversight of ways to improve bed count data collection with the input of veterans’ groups and representatives of front line employees.

Recommendation #6: AFGE strongly opposes the use of a BRAC-like process to address VHA’s facility and capital asset needs. We are equally opposed to giving a governance board any role in determining VHA’s infrastructure needs. It is likely that any board-run process would be plagued by the same self-interest that impaired the decision making process of a Commission filled with health care executives.

AFGE concurs with the Independent Budget veterans service organizations that a far more urgent need is to address current infrastructure gaps that threaten safety and interfere with care delivery. Clearly, a BRAC is not the answer. The RAND Corporation recently reported that through at least 2019, demand for veterans’ health care services is likely to exceed supply.

Recommendation #15: In its report, the Commission portrays civil service protections afforded to Title 5 employees as the enemy of innovation and quality improvement (“a relic of a bygone era”, “an island disconnected from the larger talent mar-

ket for knowledge-based professional and administrative occupations that are mission-critical"). The Commission then reveals its true agenda for eliminating Title 5 rights: it wants to make it easier to fire employees it doesn't like and hire through cronyism.

What the report does not tell us is that the Department of Defense federal agencies operate health care systems effectively with Title 5 workforces that have full due process and collective bargaining rights that they use to speak up against mismanagement and negotiate with management over working conditions to the benefit of their patients.

This recommendation would eliminate all Title 5 rights currently afforded to the majority of VHA employees. These include full Title 5 employees, most of whom are service-connected disabled veterans (e.g. police, housekeepers, food service workers) and Hybrid Title 38 employee (e.g. Medical Support Assistants, nursing assistants, pharmacists, psychologists and social workers). Both groups would lose their right to third party review of removals and demotions by the Merit System Protection Board.

Both groups would also lose most of their collective bargaining rights that allow them to negotiate over working conditions such as scheduling, assignments and training.

Veterans who choose to work in VA health care after saving lives on the battlefield would also be greatly harmed by this Commission recommendation. Federal case law has made it clear that employees appointed under Title 38 (Hybrids and full Title 38 employees) are not covered by the Veterans Employment Opportunities Act (VEOA) and therefore lack veterans preference protections against being passed over for a non-veteran in hiring. AFGE concurs with the Independent Budget that Congress should enact legislation to extend the VEOA to all VHA employees.

The proposed new Title 38 personnel system would ignore seniority when setting pay, at a time when VHA is facing low morale and increased attrition among providers with valuable experience because many new hires are being paid more than their senior counterparts.

Other recommendations

AFGE generally supports recommendations #3 (appealing clinical decisions), #5 (health care disparities), #14 (diversity and cultural competence), #16 (human capital management) and #17 (eligibility for those with other-than-honorable discharges).

AFGE supports modernized information technology (IT) (#7) but urges Congress to mandate greater involvement of front-line employees using new IT systems to ensure successful implementation.

AFGE does not take a position on recommendation #4 (VHA transformation) because further investigation of the cost-effectiveness and lack of transparency of the Veterans Engineering Resource Centers is needed. We also take no position on #8 (supply chain) or #12 (VISNs) at this time.

We object to #10 (leadership) if it involves a governance board. AFGE also opposes #11 (leadership succession) because direct hire authority will increase cronyism and discrimination against veterans. AFGE also opposes #13 (performance standards) because of its overreliance on private sector standards that are not applicable to VHA's mission or its unique patient population. AFGE is opposed to recommendation #18 (expert body to address eligibility) as unnecessary.

In closing, AFGE urges the Committee to reject all proposals to dismantle the VA health care system and shut the doors of its medical centers, either through unrestricted access to non-VA care under a governance board-run system or legislation to extend the broken temporary Choice program. Lawmakers should also investigate the growing number of incremental attacks on VA health care including outsourcing of C&P exams, contractor-run outpatient clinics and elimination of VA-provided emergency care and ICU services.

Instead, AFGE urges the Committee to serve the best interests of veterans and the Nation by investing in VA's own high performing integrated, veteran-centric health care system. AFGE welcomes the opportunity to work with the Committee and VSOs to ensure continuous improvement in our Nation's treasured health care system for veterans.

AMVETS

Chairman Miller, Ranking Member Takano, and distinguished Members of the Committee,

Since 1944, AMVETS (American Veterans) has been one of the largest congressionally-chartered veterans' service organizations in the United States and includes members from each branch of the military, including the National Guard, Reserves, and Merchant Marine. We provide support for the active military and all veterans in procuring their earned entitlements, and appreciate the opportunity to present our views at this oversight hearing, "From Tumult to Transformation: The Commission on Care and the Future of the VA Healthcare System."

As widely noted, the Commission on Care was established by section 202 of Public Law 113-146 and worked for ten months examining veterans' access issues with the Department of Veterans Affairs (VA) health care, and talked with many experts and veterans services organization leaders on how best to organize the Veterans Health Administration (VHA) to ensure successful delivery of high-quality health care to qualifying veterans over the next two decades.

The Commission released its final report on June 30, 2016 and developed 18 recommendations intended for the purpose of extensive organizational transformation, not a disjointed fix to everyday issues.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

The Commission Recommends That:

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense (DoD) and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Develop integrated community-based health care networks with input of local VHA leadership to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special emphasis resources. In areas where VHA has special expertise, VHA should enhance care by collaborating with community care providers to implement services that may not exist.
- Build out networks in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective strategic execution.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services.
- The highest priority access to the VHA Care System to be provided to service-connected and low-income veterans.
- Eliminate current time/distance criteria (30 days/40 miles) for community care access.
- Veterans choose a primary care provider from credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provides veterans with health care coordination and navigation support.
- Veterans choose their specialty care providers from credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The Commission noted that the temporary Choice Program has proven to be flawed, and that VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System. With the exception of the creation and involvement of a governing board, AMVETS supports

this recommendation and will continue to work with VA in its goal of consolidating Community Care Programs through the MyVA initiative.

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

The Commission Recommends That:

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

AMVETS is in support of this recommendation.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

The Commission Recommends That:

- VHA convene an interdisciplinary panel to assist in developing a revised clinical appeals process.

AMVETS is in support of this recommendation and believes that there needs to be a national process in place for veterans to appeal clinical decisions that is equitable and easy to understand.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

The Commission Recommends That:

- The Veterans Engineering Resource Center (VERC) assist in transformation efforts, particularly in areas of access and that affect system-wide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

AMVETS is in support of this recommendation.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Commission Recommends That:

- VHA work to eliminate health disparities by making health care equity a strategic priority.
- VHA provide the Office of Health Equity adequate resources and the authority to build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority and other vulnerable veterans with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.

AMVETS is in support of this recommendation.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

The Commission Recommends That:

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

With the exception of the creation and involvement of a governing board, AMVETS supports this recommendation.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

The Commission Recommends That:

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) IT solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

AMVETS is in support of this recommendation.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

The Commission Recommends That:

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

AMVETS is in support of this recommendation.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The Commission Recommends That:

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

AMVETS does not support establishing a board of directors to be responsible for overall VHA governance.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

The Commission Recommends That:

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress and report on it to the CVCS and the new VHA Care System board of directors.

With the exception of the creation and involvement of a governing board, AMVETS supports this recommendation.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

The Commission Recommends That:

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

AMVETS is in support of this recommendation.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

The Commission Recommends That:

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.

- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

AMVETS is in support of this recommendation.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

The Commission Recommends That:

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

AMVETS is in support of this recommendation.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The Commission Recommends That:

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

AMVETS is in support of this recommendation.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

The Commission Recommends That:

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that:
- Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer;
- Promotes veteran preferences and hiring;

- Embodies merit system principles through simplified, sensible processes that work for managers and employees;
- Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes;
- Provides due process and appeals standards to adverse personnel actions;
- Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade);
- Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits;
- Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement;
- Eliminates most distinctions (except for benefits) between part-time and full-time employees; and
- Grandfathers current employees with respect to pay and benefits.

- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

AMVETS is in support of this recommendation and believes it is crucial for recruiting and retention that VHA employees receive pay and benefits on par with the private sector, and that reliable funding in place to ensure the continuity of this measure.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

The Commission Recommends That:

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

AMVETS is in support of this recommendation.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

The Commission Recommends That:

- VA revise its regulations to provide tentative eligibility to receive health care to former servicemembers with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

AMVETS is in support of this recommendation and emphasizes those "who are likely to be deemed eligible" instead of a blanket opening of the system to all veterans with an other-than honorable discharge. Our organization has heard from many veterans who were improperly diagnosed or treated for their invisible wounds - some 40 years ago and others much more recently. Considerable progress has been made in the last decade in regards to identifying behavioral and physical symptoms of mild-to-moderate traumatic brain injuries and post-traumatic stress disorder. Veterans who honorably served prior to exhibiting these symptoms deserve a path to eligibility to access the specialized health care that VA offers.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

The Commission Recommends That:

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for non-veterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

AMVETS is not in support of this recommendation. On March 13, 2015 VA announced the formation of the MyVA Advisory Committee (MVAC) which brought together experts from the private, non-profit, and government sectors to advise the Secretary of Veterans Affairs on improving customer service, veteran outcomes, and setting the course for long-term reform and excellence. MVAC currently has 12 priorities which are to:

- Improve the Veterans Experience
- Increase Access to Health Care
- Improve Community Care
- Deliver a Unified Veterans Experience
- Modernize VA's Contact Centers
- Improve the Comp & Pension Exam
- Develop a Simplified Appeals Process
- Continue to Reduce Veteran Homelessness
- Improve Employee Experience
- Staff Critical Positions
- Transform OIT
- Transform Supply Chain

AMVETS believes it would be in the best interest of VA to continue to work with the MVAC on additional goals, as needed, but to not dilute the current well-founded relationship. In fact, many of the recommendations in the Commission on Care report touch on the priorities that VA is working towards and where they have acknowledged work needs to be done.

It is clear from many ongoing and recent reports that the VA health care veterans receive is on par or better than the private sector, high-quality, specialized, and patients are satisfied with the outcome. Access to care remains the most unstable part of the equation, yet measureable progress is being made. As stated earlier, AMVETS supports VA's plan to consolidate community care to address the access issue, and looks forward to its further implementation.

Mr. Chairman and members of the Committee, this concludes my testimony and would be happy to answer any questions the Committee may have.

CONCERNED VETERANS FOR AMERICA

Chairman Miller, Ranking Member Takano and distinguished members of the Committee, thank you for allowing Concerned Veterans for America to submit for the record on this important issue. In 2014, as the Nation stood in shock at the revelation that VA had manipulated data contributing to the deaths of veterans, Congress acted quickly, passing the Veterans Access, Choice and Accountability Act of 2014. That legislation included, among other things, a requirement that a commission be established in order to examine the state of VA health care and to make recommendations as to how it might be improved. On June 30th, 2016, the Commission on Care released its final report outlining its recommendations for the future of VA health care after nearly nine months of deliberation.

The Commission had a legislative mandate requiring the implementation of all recommendations that the President considers feasible, advisable, and able to be implemented without legislation. Thus, it was uniquely empowered to make bold recommendations regarding the future of veteran health care.

As was shown by the Independent Assessment—which was also mandated by the Veterans Access, Choice and Accountability Act of 2014 and was released in September, 2015—“Solving [the] problems [at VA] will demand far-reaching and complex changes that, when taken together, amount to no less than a system-wide reworking of VHA.”¹ Unfortunately, the Commission's recommendations amount to far less.

¹ The MITRE Corporation. (September, 2015). Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Volume I: Integrated Report, 17.

To be sure, there are aspects of the recommendations that represent real progress for veteran health care delivery.

Currently, veterans who use VA are the only constituency in the country that does not, as a matter of course, have choice in how they receive their health care—including federal employees and Medicaid users. The Commission's recommendations aim to give veterans increased options in this regard. Injecting the principle that veterans should have the same opportunities as the rest of the population to select the health care delivery that best suits their needs is a step in the right direction; this is progress.

Furthermore, the Commission recommends that the governance of VHA be restructured to include a board of directors. This is a recommendation that has resurfaced time and again, from the 2009 report of the Commission on the Future for America's Veterans²—whose signatories included representatives of The American Legion and Disabled American Veterans—to the Fixing Veterans Health Care Task Force Report put forth by our organization. Currently, VA governance—a combination of bureaucratic and congressional management-functions to undermine rationalization of VHA operations. As the Commission's final report states “New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors”.³ This is also progress.

In addition, the recommendations include an appeal to Congress to “enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care.”⁴ This much-needed VHA facility realignment would allow under-utilized and outdated facilities to be jettisoned, allowing the funds required for up-keep to be redirected toward caring for veterans. As the report notes, “If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.”⁵

Unfortunately, however, the recommendations stop short of bold transformation that would constitute a true “system-wide reworking,” opting instead for a set of recommendations that, as mentioned, have good aspects, but are unlikely to ultimately address the problems that VA faces.

Over the course of the Commission's meetings, some in the media began to preemptively question the very legitimacy of the Commission by questioning the notion that there had, in fact, been a scandal at VA at all, and noting that the Commission had been created out of the legislative response to the scandal. This was, apparently, because there was fear regarding what kinds of proposals might be put forth by the Commission. While these attempts at de-legitimization of the Commission were largely unsuccessful, the relative timidity of the Commission's final report reflected the effects of the attacks.

Though it is true that the recommendations incorporate the principle of choice, they effectively leave VA at the center of the decision-making process regarding where and how veterans receive care.

The recommendations stipulate that VA should establish “Integrated community-based health care networks” in response to the “misalignment of capacity and demand that threatens to become worse over time”.⁶ This, no doubt, is the result of the Commission attempting to “split the difference” between the measures required to create a truly high-performing, veteran-centric system and the scruples of some stakeholders whose lack of imagination or ideological pre-commitments constrain the range of possibilities that they will entertain. While this recommendation understandably attempts to balance concerns about care coordination with increased choice, by insisting that VA remain in control of credentialing providers, VA remains very much at the center of the decision-making process—not the veteran.

Furthermore, the establishing and credentialing of provider networks—which sounds like a relatively simple task—is actually far more complicated than it seems. The Commission's recommendation essentially proposes a system that resembles TRICARE Prime—a system that has proven unworkable. In fact, last year the Military Compensation and Retirement Modernization Commission (MCRMC) recommended it be replaced by “TRICARE Choice,” an updated model which would

² Walters, H. et al. (2009, December). Commission on the Future for America's Veterans: Preparing for the Next Generation. Commission on the Future for America's Veterans.

³ Schlichting, N. et al. (June, 2016), Commission on Care Final Report. 98.

⁴ Ibid., 60.

⁵ Ibid., 61.

⁶ Ibid., 23.

allow “beneficiaries to choose from a selection of commercial insurance plans offered through a Department of Defense health benefit program.”⁷ As *Military Times* reported, “Under that proposal, beneficiaries would choose a health plan from a menu of programs compiled by the federal Office of Personnel Management, similar to the health plans offered to federal employees.”⁸ Considering that VA has had difficulty meeting its current responsibilities, it is not easy to see how it can be expected to effectively do what the Department of Defense was unable to with TRICARE Prime.⁹

The Independent Assessment admonishes that VA is in need of a “system wide reworking” in order to meet its responsibilities. Maintaining the current system as-is, while tacking on the added responsibility of establishing and operating networks based loosely on a failed model, would only compound VA’s challenges.

There are three other areas where the recommendations are deficient.

First, there is a need, before anything else, to analyze and update the overall eligibility and benefits package to determine whether and to what extent it needs to be altered. The Commission recommendations rely on an outdated eligibility and benefit package that has not been critically analyzed and updated since the enactment of the Veterans’ Health Care Eligibility Reform Act of 1996. Recommendation Number 18 proposes the “Establish[ment of] an expert body to develop recommendations for VA care eligibility and benefit design.”¹⁰ Until the VA eligibility and the benefits package is updated and modernized, the other Commission recommendations will be hampered and only partially effective for operations, cost, quality and access improvement, as they will remain out of sync with the best practices of modern health care systems.

Second, although there were some high-level cost estimates of alternative policy proposals, the recommendations do not include the effect of cost mitigation strategies and options that reduce risk for VHA policy and planning. For example, documents prepared by Milliman Inc. and presented to the Commission indicate that, given certain assumptions, Care in the Community could actually be cheaper than care received in VA.¹¹ Clearly, more careful consideration of the cost/savings possibilities is needed.

Third, both the Independent Assessment and the Commission on Care have identified a need to conduct a survey representative of the views of millions of veterans receiving health care from VHA.¹² An effective model for this kind of a comprehensive survey of veterans health care needs and preferences would be those done by the MCMRC and cited in their 2015 report.¹³ Until this is done, it will be difficult to ascertain exactly what kinds of policies might meet the needs of veterans as they understand them.

A Way Forward

While it is true that more data and analysis are needed, there are policy proposals available that we believe represent a better way forward.

In June, Rep. Cathy McMorris-Rodgers released a discussion draft of a bill entitled *The Caring for Our Heroes in the 21st Century Act*.¹⁴ We believe this discussion draft contains an excellent proposal that reflects the kind of comprehensive health care reform that VA needs. It utilizes a systems approach that contains all of the components needed to fix the VA health care system in a fiscally responsible way. Notably, all of the Commission on Care recommendations are, to a greater or lesser extent, compatible with this legislation. And, by including an implementation

⁷ Maldon, A., et al. (January, 2015) Report of the Military Compensation and Retirement Modernization Commission, 79.

⁸ Kime, Patricia, “Tricare Choice: What’s in it for you?,” *Military Times*, March 16, 2015, <http://www.militarytimes.com/story/military/benefits/health-care/2015/03/16/commission-proposes-tricare-choice/24458697/>.

⁹ In 2013, TRICARE made some fairly drastic changes to, and reductions in, the availability of TRICARE Prime. For an overview see, for example, <http://uhs.fsu.edu/insurance/newDocs/PSA-Reduction-FS.pdf>.

¹⁰ Schlichting, N., et al. (June, 2016), Commission on Care Final Report, 161.

¹¹ Jamie Taber, Gideon Lukens, and Merideth Randles, “Estimating Costs for Veterans Health Part 2,” (presentation, Commission on Care, Washington, DC, March 22-23, 2016), 7. <https://commissiononcare.sites.usa.gov/files/2016/03/Estimating-Costs-for-Veterans-Health-Part-2-Day-2-032316-1.pdf>

¹² See, e.g. The MITRE Corporation. (September, 2015). Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Volume I: Integrated Report, 2 and A-3.

¹³ Maldon, A., et al. (January, 2015) Report of the Military Compensation and Retirement Modernization Commission, 209.

¹⁴ Full text can be found here: <https://mcmorris.house.gov/wp-content/uploads/2016/06/McMorris-Rodgers-Discussion-Draft-VA.pdf>.

commission in the proposal, the legislation would provide a mechanism for further improvement based on the additional cost, survey and systems data and analysis referenced above.

The Caring for Our Heroes in the 21st Century Act offers a truly new way of looking at veterans' health care. It goes beyond the VA's current centralized model that traps veterans into a deficient system of unresponsive and inconsistent care, instead creating a system that is flexible and adaptable to the needs of the individual veteran and their family. It is, in our opinion, the best legislative proposal aimed at fixing VA health care that has yet been put forth. This is because it prioritizes the needs of veterans over the VA bureaucracy and seeks to transform a dated, sclerotic government agency into a high-functioning modern health care organization. It represents a change that is long overdue and one that our veterans deserve.

Reform is never easy, but veterans deserve nothing less.

For questions or additional information regarding this testimony, please contact Mr. Shaun Rieley at Concerned Veterans for America, srieley@cv4a.org or 517-447-3542.

Disabled American Veterans (DAV)

Chairman Miller, Acting Ranking Member Takano, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record on the report and recommendations of the Commission on Care to improve the veterans health care delivery system over the next twenty years. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Virtually all of our members rely on the Department of Veterans Affairs (VA) health care system for some or all of their health care, particularly for specialized treatment related to injuries and illnesses they incurred in service to the Nation.

Mr. Chairman, since the waiting list scandal and access crisis were uncovered by Congress and the national media in the spring of 2014, a vigorous national debate has commenced about how best VA should provide timely, high-quality, comprehensive and veteran-focused health care to our Nation's veterans. After dozens of Congressional hearings, multiple internal reviews, numerous media investigations, enactment of temporary programs and laws, expert stakeholder input, an independent assessment, and recently the final report from the Commission on Care, all parties need to move from debating VA's future to creating the future VA health care system America's veterans deserve.

With the current veterans "choice" program set to expire next year, Congress and VA must now choose whether to extend, expand or otherwise modify the current choice program, or to move beyond it to develop a new system of care based upon an integrated network of VA and community providers capable of meeting veterans health care needs in the future.

As this Committee is well aware, Congress passed the Veterans Access, Choice, and Accountability Act (Public Law 113-146) in August 2014 in direct response to the access crisis and waiting list scandal at the Phoenix, AZ VA Medical Center and other locations around the VA system. The primary purpose of the Choice Act was to address veterans' access barriers by creating a new temporary choice program that allowed certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for requested care, or travel more than 40 miles to a VA facility to receive requested care. The act also required an outside, independent assessment of the VA health care system, and it established the Commission on Care to study and develop recommendations for VA to improve the delivery of health care to veterans on a longer term basis.

Since its inception two years ago, the choice program has been beset with problems, some caused by the design of the law and others due to the urgent implementation schedule mandated by Congress. As the number of veterans using the choice program has risen, so have the number of problems they have encountered related to care coordination, appointment scheduling and provider payments. Although DAV and other VSOs supported passage of the choice program as an emergency response to the access crisis, it was neither intended to be nor supported as a permanent centerpiece of VA's health care delivery model. To address technical and implementation challenges with the choice program, Congress enacted two subsequent acts (Public Laws 113-175 and 114-41) but has not made any further legislative changes while awaiting the Commission on Care's final report.

The Independent Assessment mandated by Public Law 113–146, conducted primarily by the MITRE and Rand Corporations., produced voluminous data, information and recommendations about improving health care to veterans. The first and most important finding of the assessment was that the root cause of VA’s access problems was a “misalignment of demand with available resources both overall and locally.” leading to the conclusion that “increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care.” in the future.¹ Further, despite these deficits, the assessment confirmed what DAV, other VSOs and dozens of independent studies have reported over the past two decades: VA quality of care, on average, is as good as or better than, care in the private sector.

Last year, as mandated by Public Law 114–41, VA developed and submitted a plan to Congress to consolidate non-VA community care programs, including the choice program. VA’s plan would create a high-performing network comprised of both VA and linked community providers. Although VA has already begun taking steps to move forward with a consolidation plan, VA is awaiting Congress to enact enabling legislation to facilitate the new consolidated program that would bring VA’s plan to fruition.

Furthermore, the Independent Budget (IB) veterans service organizations (DAV, the Veterans of Foreign Wars, and Paralyzed Veterans of America) developed a joint Framework for Veterans Health Care Reform that proposed a similar concept of local veteran-focused integrated health care networks. Both the IB framework and the VA plan call for VA to remain the coordinator and primary provider of care, with community providers integrated when needed to guarantee veterans access to care. This integrated network approach has been publicly supported by dozens of other veterans and related organizations, reflecting the views and sentiments of millions of veterans they, and DAV, represent.

The Commission on Care spent almost a year reviewing the Independent Assessment, hearing from stakeholders and other outside experts, and developing its recommendations to improve health care for veterans. While the Commission considered a wide range of ideas and options, including proposals to privatize VA, and one plan (the “strawman proposal”) that called for dismantling the VA health care system over the next two decades. Ultimately, the Commission rejected the radical ideas, instead reaching a consensus on recommendations that hold many similarities to the plans put forward by VA and mainstream veterans organizations. The first and foremost Commission recommendation calls for establishment of “high-performing, integrated community-based health care networks” with VA acting as the coordinator and primary provider of care. Although some important differences are apparent among the integrated network plan proposed by the Commission, the IBVSOs and VA, respectively, each of the three proponents calls for strengthening the existing VA health care system by incorporating community providers into integrated networks. Moreover, each proposal maintains VA as the coordinator and primary provider of care, and each views the use of community providers and choice as a limited means to expand access in circumstances in which VA is unable to meet local demand for care.

After two years of spirited and passionate debate about the future of veterans health care, we envision a clear path forward that builds on the strengths of the existing VA system, while expanding access by seamlessly integrating the best of community care to ensure no veteran must travel too far or wait too long for care. Congress and VA must now begin the steps to finalize plans and move forward with the evolution of veterans health care. Equally important, both Congress and the next Administration must make a commitment to ensure that the resources necessary to complete this transformation.

While we agree with most of the Commission’s recommendations to strengthen the leadership, management and operation of the VA health care system, some remain of concern to us, and are explained below.

Recommendation #1:

Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Based on National Resolution No. 238, adopted by delegates to our most recent National Convention, that calls for specific reforms in VA health care, DAV supports

¹ Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, The MITRE Corporation, September 1, 2015, p. B-3.

the overall structure and intent of this recommendation to create integrated networks. Nevertheless, our resolution does not support the recommended option to allow veterans to choose any primary or specialty care provider in a network made up of VA and private care providers because it would result in less coordinated care, worse health outcomes, lower overall quality and significantly higher costs that could ultimately endanger the overall VA system of care that millions of veterans rely on, particularly veterans who were injured or made ill during military service.

As the Commission report states, “Veterans who receive health care exclusively through VHA generally receive well-coordinated care. [whereas] ...fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.”² While veterans’ individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high quality for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the Commission’s report states, “Well-managed, narrow networks can maximize clinical quality.” and, “Achieving high quality and cost effectiveness may constrain consumer choice.”³

Furthermore, the Commission’s recommended option to allow every individual veteran to determine which VA or non-VA providers in the network they would use could affect access for other veterans and could lead to increased costs. The Commission itself notes that in establishing networks, VA “must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans’ choice, yet would also consume far more financial resources.”⁴ In fact, the Commission’s economists estimate that the recommended option could increase VA spending by at least \$5 billion in the first full year, and that it could be as high as \$35 billion without strong management control of the network. The Commission also considered a more expanded choice option to allow veterans the ability to choose any VA or non-VA provider - without requiring them to be part of any defined network - and the economists estimated such a plan could cost up to \$2 trillion more than current VA expenditures over the first ten years.

While we agree that the VA health care system must evolve by integrating community providers into its networks, VA must retain the ability to coordinate care and manage workload within the networks. In general, the networks must have the ability to expand to include community providers if veterans face access challenges or VA is unable to provide sufficiently high quality care. The size, scope and design of local networks, as well as clinical workflow, must be directed by VA based on a demand-capacity analysis in each market in order to assure quality and adequate access to care.

DAV is particularly concerned about the Commission’s projection that more than 40% of the medical care currently provided inside VA facilities would shift to non-VA network providers if this recommended option is implemented.⁵ Note that the “40% estimate is derived from the Commission’s estimate that 60% of the 68% of care that is eligible for community care under the recommended option would shift.) Such a large transfer of patient care workload from VA facilities would produce a dramatic impact on VA’s ability to maintain a critical mass of patients necessary to safely and efficiently operate its programs and facilities. An outflow of workload of this magnitude would undoubtedly lead to a number of facilities cutting services or closing, thereby depriving veterans of the option to receive all or even any of their care from VA providers. The elimination of VA as an option would be particularly devastating for severely injured, ill and disabled veterans who rely on VA for specialized care.

Furthermore, we are alarmed that the Commission report specifically states that no consideration was given to whether its recommended option would weaken or diminish VA’s medical and prosthetic research, academic, and national emergency preparedness missions, which continue to be vital aspects of the VA health care system overall. In particular, the VA research program serves as a harbor to ensure that veterans receive the most current, safest and most effective treatments available for service-related conditions, and to advance the standard of health care both within VA and beyond. The report also explicitly states that the Commission did not consider whether a sufficient number of private providers would be willing to take on additional patient loads from VA at Medicare reimbursement rates, how such a shift from VA to private providers would affect underserved communities, or how

² Commission on Care Final Report, June 30, 2016, p. 28.

³ Commission on Care Final Report, June 30, 2016, p. 28.

⁴ Ibid.

⁵ Ibid, p. 31.

reduced patient workload within VA facilities would affect the quality of care of veterans remaining in the VA system.⁶

In addition to these concerns, it is critical to emphasize that the creation of seamless integrated community networks cannot be accomplished quickly or without a significant infusion of new resources to develop and deploy a modern IT and management infrastructure necessary to successfully operate the networks, particularly to achieve seamless scheduling, care coordination and provider payment functions. We agree with the Commission that networks should be, “. built out in a well-planned, phased approach.”⁷ Furthermore, it is imperative that before and during the development of these networks, VA should regularly consult and collaborate with local and national veterans organizations and leaders, as well as other key stakeholders and community partners to gauge progress.

Recommendation #6:

Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

DAV agrees with the recommendation to streamline and strengthen VA's facility and capital asset program management and operations. We also agree with the recommendation to give VA greater budgetary flexibility to meet its facility and capital asset needs, particularly overcoming Congressional budget scoring rules that have complicated VA's ability to open new leased clinic space. We also agree that VA needs to have the ability to realign its health care resources to address changes in the veteran population, demographics, location and health care needs, as well as evolving health science and technology. However, we do not agree that it is necessary or advisable to create an inflexible process, similar to the BRAC process, which has been employed to close military bases. The development of integrated community networks must be based on dynamic demand and capacity analysis, which would include modeling of the need to expand, contract, or relocate VA facilities. Local stakeholder input would be essential to ensure that local health care coverage would not be negatively affected by any facility realignment. DAV and our IB partners also believe that expanded usage of public-private partnerships should be explored as another way to address VA's infrastructure needs.

However, even with these reforms, significant increases in infrastructure funding will be necessary to address VA's access challenges. The Independent Assessment discussed earlier in this statement found that the, “.capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen.”⁸ Without change, the estimated gap will be between \$26 and \$36 billion over the next decade. For FY 2017, DAV and our IB partners recommended \$2.5 billion for all VA infrastructure programs; however, the Administration requested only \$1 billion. Both chambers of Congress settled for this inadequate funding level in this pending appropriation. While certainly a need exists to maximize savings from closing unused or underutilized facilities, the Commission's report points out that these savings are estimated at only \$26 million per year, an amount that would not begin to make up for the shortfall in infrastructure spending required to maintain the remaining VA system. Also, under budget formulation policies, any such savings from closed or downsized facilities most likely would be lost to VA. Unless Congress and future Administrations begin to provide realistic funding levels to repair, maintain and replace existing VA health care infrastructure, these reforms will be significantly challenged.

Recommendation #9:

Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

DAV does not support the recommendation to take control of the VA health care system away from the VA Secretary and give it to an unelected, independent Board of Directors that would be less accountable to the President, Congress, veterans and the American people. Separating veterans health care services from other veterans benefits and services would result in a loss of comprehensive and coordinated support for veterans, particularly those injured or ill from their service. Creating another layer of bureaucracy between veterans and the VA health care system would create more problems than solutions. We appreciate the Commission's interest in

⁶ Commission on Care Final Report, June 30, 2016, pp. 32-33.

⁷ Ibid, p. 4.

⁸ Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, The MITRE Corporation, September 1, 2015, p. K-1.

recommending greater stability and continuity of leadership; however, better means are available to accomplish these goals without undercutting VA's uniquely integrated system of services and benefits.

Rather than create an inherently political and bureaucratic layer between veterans and their health care system, these same purposes could be accomplished through the establishment of strategic planning mechanisms currently being used by the Departments of Defense and Homeland Security. Specifically, we propose that VA be required to undergo a Quadrennial Veterans Review (QVR), similar to the Quadrennial Defense Review (QDR) and Quadrennial Homeland Security Review (QHSR). The QVR, similar to its counterparts, would establish a national strategy to guide the creation of federal policies and programs for veterans, and would be timed to overlap with Presidential administrations to provide continuity and insulation from political influence.

In addition, similar to the Departments of Defense and Homeland Security, there should be established a Future Year Veterans Program (FYVP) that would establish five-year resource needs and projections that VA would need in order to implement the policies and programs set out in the QVR. VA should also fully convert its budgeting and spending systems to a Planning, Programming, Budgeting and Execution (PPBE) system also used by the Departments of Defense and Homeland Security in order to assure accountability in how VA allocates its resources to meet immediate, short-term and long-term strategic goals. Establishing new planning and budgeting functions could provide VA stability and continuity in a more practical, effective and feasible manner than trying to establish a semi-independent governance board.

In addition, consideration should be given to overlapping the terms of the Under Secretary for Health and other senior VA leaders with Presidential elections, to provide additional stability and continuity, and to insulate these officials from political influence.

ADDITIONAL COMMENTS ON COMMISSION ON CARE RECOMMENDATIONS

Recommendation #2:

Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

DAV supports this recommendation but notes that additional funding would be essential in order for VA to hire the new support staff discussed by the Commission.

Recommendation #3:

Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-funded programs.

DAV supports the recommendation to create a fair, transparent and timely process to appeal clinical decisions, and we have testified before Congress on this concept. We would emphasize the importance of including veteran patients and veterans advocates during the development of this procedure.

Recommendation #4:

Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

DAV supports the recommendation for VHA to adopt a model of continuous improvement and to share and standardize best practices in accordance with our Resolution No. 244, which calls for VA to maintain a comprehensive health care system for enrolled veterans, endemic to which is continuous improvement and the advent of best practices. We also agree that the three Veterans Engineering Resource Centers should play a more prominent role in the maintenance and improvement of such a system. Currently, VA employs numerous clinical researchers and operates numerous centers of excellence, health services research and development centers, and other centers devoted to continuous improvement, quality enhancement, patient safety and other factors affecting the state of care for veterans' health. Each has its own history, mission and proven accomplishments that have and continue to serve veterans. In addition, because systems engineering, as with other systemic change approaches, has limitations particularly in network-based complex adaptive systems, such limitations should also be considered when implementing this recommendation.

Recommendation #5:

Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

DAV supports the recommendation to more effectively address health care equity issues. We refer the Committee to DAV's 2014 report, *Women Veterans: The Long Journey Home*, which details the barriers and program inequities that women veterans face. Our report offered specific recommendations to remedy these challenges.

Recommendation #7:

Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

DAV supports the recommendation to modernize and give VHA functional control over its IT systems in accordance with our recommendations in the IB. To assure full coordination of the proposed integrated networks will require full implementation of new IT systems and complete interoperability across VA and network providers. We would again note that significant time and dedicated resources will be required to achieve this goal.

Recommendation #8:

Transform the management of the supply chain in VHA.

DAV generally agrees with this recommendation. We would note in consonance with our recommendations in the IB that some supply and acquisition programs and services are critically important to veterans, such as those affecting the procurement of prosthetics and sensory aids. Careful consideration must be given to balancing national standardization concepts with local flexibility to meet the unique needs and preferences of veterans who need these specialized services to address their disabilities.

Recommendation #10:

Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

DAV supports this recommendation, on the basis of National Resolution No. 238, urging VA to adopt a broad reform agenda for the future in health care, and in that respect would note our specific support for VA's MyVA initiative that is already beginning to address these concerns.

Recommendation #11:

Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

DAV supports the intent of this recommendation on the basis of our recommendations in the IB dealing with the need for reforms in VA's human resources management programs, and again notes that VA's MyVA initiative and other new leadership programs are also beginning to address these issues.

Recommendation #12:

Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

DAV supports eliminating waste and redundancy and standardization where possible; however, because this recommendation would impact such a large part of VHA organizational structure, we believe it requires further study.

Recommendation #13:

Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

DAV generally supports the intent of this recommendation, although we would emphasize that not all performance metrics could or should be identical to those

used in the private sector due to the unique nature of the VA health care system and the significant differences between patient case mix in VA facilities versus those in private care. Health care outcomes and patient satisfaction could be measured consistently between VA and private providers; however, metrics related to cost, value or efficiency are less likely to provide meaningful comparisons because of differences in how VA and private systems are funded, the role of private health insurance, the primary-preventative model of VA health care and the interconnection of VA's complementary services and benefits—none of which generally exist in private care. VA should continue to develop and optimize metrics that provide meaningful feedback about its unique health care model, as well as help develop new benchmarks that both VA and the private sector can use to strengthen performance measurement.

Recommendation #14:

Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

DAV generally agrees with this recommendation. In terms of providing military culture competency, VA providers are generally well-trained, though there remains room for improvement. As networks are developed, transferring some level of military/veteran cultural competency to non-VA providers will be critical, although they may never possess the same level of immersion or understanding about the impact of military service as VA providers who work full-time inside a veteran-focused environment. We would also agree that non-VA providers should be expected to deliver the same level of veteran-focused care as VA providers, such as by requiring all providers to ask patients about their military history and possible toxic exposures, as is required for VA providers.

Recommendation #15:

Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

DAV recognizes the need to strengthen VA's ability to recruit, hire, retain and hold accountable all VA employees. Nevertheless, we do not take a position on whether the creation of an alternative personnel system would be the best way to accomplish these goals.

Recommendation #16:

Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

DAV supports this recommendation on the basis of our human resources management concerns expressed in the IB.

Recommendation #17:

Provide a streamlined path to eligibility for health care for those with an other than honorable discharge who have substantial honorable service.

DAV supports this recommendation on the basis of our National Resolution No. 226, adopted by delegates to our most recent National Convention, which calls for a more liberal review of other than honorable discharges for purposes of receiving VA benefits and health care services in cases of former servicemembers whose post-traumatic stress disorder, traumatic brain injury and military sexual trauma or other trauma contributed to their administrative discharges characterized as other than honorable.

Recommendation #18:

Establish an expert body to develop recommendations for VA care eligibility and benefit design.

DAV does not believe a new commission or task force is needed to make adjustments to veterans health care eligibility or benefits design. The Secretary already possesses tools to control access through enrollment decisions, and Congress retains complete discretion to modify eligibility requirements, to adjust the health care benefits package or other benefits through the legislative process.

Mr. Chairman, this concludes DAV's testimony. We thank the Committee for inviting DAV to submit this testimony for the record, and we are prepared to respond to any questions by Committee Members on the Commission's report and our positions on VA health care reform.

THE AMERICAN LEGION

Chairman Miller, Acting Ranking Member Takano and distinguished members of the Committee, on behalf of National Commander Charles E. Schmidt and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to comment regarding The American Legion's position on the Commission on Care and the future of the VA health care system.

The American Legion has worked extensively on matters concerning veterans for nearly 100 years. Our work includes all business lines managed and operated by The Department of Veterans Affairs (VA) through sustained physical involvement, review of national policy, and donations of resources, funding, personnel, and experience.

It is with the voice and support of the largest voting block of veterans in the country that The American Legion presents the following analysis and recommendations regarding the report offered by The Commission on Care dated June 30, 2016.

The American Legion acknowledges the Commission relied heavily on the Independent Assessment as per congressional instructions, as well as some limited testimony from VA, Veteran Service Organizations (VSO), and media reports; but the primary foundation for discussion and findings were based on internal discussions among commissioners based on individual filters, experiences, and loyalties; and thus this report is reflective of those individual opinions.

The American Legion will not address the entire report, rather we will highlight the parts we believe have merit for further study or implementation, and those areas where we believe implementation would be detrimental to all veterans seeking health care from the VA, whether directly, or through a managed community relationship.

We are in general agreement with most of the Commission's recommendations and are pleased to see they are in line with transformation currently underway at VA through the MyVA initiative.

As you know, three of 15 Commission members did not sign the final report, with two commissioners opposing the final report because they felt it didn't go far enough. Commissioner Michael Blecker also did not sign, saying the main recommendation, for the Veterans Health Administration (VHA) Care System, went too far.

The American Legion's positioning on the report places us closer to Commissioner Blecker's. As he explained in his June 29 dissent:

*I cannot agree to the Commission's first and most significant recommendation, establishment of a proposed "VHA Care System." Given the design of this proposed new delivery model, the adoption of this proposal would threaten the survival of our nation's veteran-centered health care system as a choice for the millions of veterans who rely on it. Although this is only one of many recommendations in the Report, this single recommendation risks undermining rather than strengthening our veteran-centered health care system, and I cannot agree to it.*¹

We also believe that recommendations of more privatization that some are trying to mask as "Choice" fail to take into consideration that veterans already have a myriad of choices, more so than most Americans. Choosing to see a contracted primary care physician as opposed to a VA primary care physician is a choice most veterans using VA health care already have through their private insurance, Tricare, Medicare, Medicaid or several other options. These "choices" also come with additional expenses to the veteran. Converting VA health care to an insurance payer would increase out-of-pocket expenses for veterans who rely solely on VA for all of their health care needs, and who may not have alternate insurance options.

That said, here are our initial comments on a few of the most important recommendations:

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks,

¹ <http://www.prweb.com/releases/2016/07/prweb13535231.htm>

to be known as the VHA Care System, from which veterans will access high-quality health care services.

This recommendation includes several sub-recommendations. Here we will address two of the most salient ones separately because they each have separate and distinct implications and will require individualized policy and/or legislative modifications in order to accomplish. The overarching theme of this recommendation involves a robust and integrated community care network.

A. The American Legion supports realigning VA's community care program and has provided testimony that discusses its restructuring. In relevant part, we said:

The American Legion believes in a strong, robust veterans' health care system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances there are situations where the system cannot keep up with the health care needs of the growing veteran population requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion has called for the Department of Veterans Affairs (VA) to "develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account."²

Over the years, VA has implemented a number of non-VA care programs to manage veterans' health care when such care is not available at a VA facility, could not be provided in a timely manner, or is more cost effective through contracting vehicles. Programs such as Fee-Basis, Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program (VCP) were enacted by Congress to ensure eligible veterans could be referred outside the VA for needed, and timely, health care services.

Congress created the VCP after learning in 2014 that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

Therefore, Congress passed the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015 after VA sought the opportunity to consolidate its multiple care in the community authorities and programs. This legislation required VA to develop a plan to consolidate existing community care programs.

On October 30, 2015, VA delivered to Congress the department's Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan seeks to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other federal health care providers, academic affiliates and community providers. It promises to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care.

Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New Veterans Choice Program (New VCP). We believe it has the potential to improve and expand veterans' access to health care.

Network Structure

The American Legion supports allowing VA to set up tiered networks. As we understand it, this structure is meant to empower veterans to make informed choices, provide access to the highest possible quality care by identifying the best performing providers in the community, and enabling better coordination of care for better outcomes. However, it does not dictate how veterans will use the network. The American Legion wants to make clear, though, that we do not support a wholesale option to circumvent the VA infrastructure or health care system entirely.

Prompt Pay

We support a provision mandating that all claims be made electronically by January 1, 2019 and an eligible provider should submit claims to Secretary within 180 days of furnishing care or services.

² Resolution No. 46: (Oct 2012): Department of Veterans Affairs (VA) Non-VA Care Programs

Episode of Care

Provisions ensuring that an eligible veteran receives such care and services through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the treatment recommended in the course of such care and services.

Emergency/Urgent Treatment

The American Legion supports requiring VA to reimburse veterans for the reasonable value of emergency treatment or urgent care furnished in a non-Department facility in a final bill.

Conclusion

Ensuring veterans have access to appropriate, timely, high-quality care is critical. VA needs to overhaul its outside care reimbursement programs, consolidating them into a more efficient bureaucracy able to dynamically interact with the network of federal, public, and private providers that are to supplement VA direct provided care.³

B.Choice of primary care provider

The American Legion opposes allowing a complete option of primary care providers within the proposed VHA Care System based on the Commission's faulty analysis. The Commission supports this recommendation based on a Congressional Budget Office (CBO) estimate of cost that was calculated using Medicare rates. The Commission, however, gave no consideration to Medicare rules for billing structure and how those rules would apply to the current quality of care provided to veterans through VHA primary care physicians. VHA physicians are not restricted as to the amount of time they are able to dedicate to each patient, or the number of presentations per patient. Medicare, on the other hand only provides payment based on a 10 or 15 minute consultation, which then denies veterans the full complement and quality of care they are entitled to through their earned benefits. If scored by CBO properly, the cost of this recommendation would be at least triple if not more, and is thus financially unsustainable. The American Legion finds the recommendation and subsequent analysis by the Commission to be in error and believe that it should not be considered by the Administration.

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The American Legion does not support the creation of a governing board. We do find value in the Commission's discussion and recommendations that point out inconsistent leadership due to rotating political appointments and a leadership vision with a lack of continuity. The American Legion supports appointing a Veterans Health Administration (VHA) leader for a minimum of a 5 year term, with an option for an additional 5 year reappointment. We could also support the same consistency for the Deputy Secretary position.

Congress is also part of the problem here. When Representative Beto O'Rourke addressed the Commission on Care on March 22nd of this year, he noted that part of the problem with VA has been a severe lack of continuity in oversight due to an unwillingness of Members to serve on the VA Committees: it's not glamorous, there are real problems to be addressed, and there are no "mission accomplished" banners. Members tend to leave the Committee as soon as they are able - to the point that, on day one as a new congressman assigned to the Committee, he found himself third in seniority on the Democratic side.

The American Legion thinks consideration should also be given to proposals that the Secretary of Veterans Affairs develop and submit to Congress a Future-Years Veterans Program and a quadrennial veteran's review.⁴

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

This proposal to shift all 300,000 VHA employees away from Title Five and onto Title 38 to provide the department with more flexibility in pay, benefits and recruiting is worth serious consideration. While the change would be designed to ease hir-

³ <http://www.legion.org/legislative/testimony/231623/pending-veterans-affairs-legislation>

⁴ <https://www.congress.gov/bills/114/congress/house-bill/216>

ing and firing at the agency, the report says the new system should maintain due process appeal rights and merit system principles and we concur.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Included in this recommendation is consideration of the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline.

As the report notes, "closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges."

Appendix C of the report discusses the outline of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas. The American Legion supports further investigation of this proposal.

The American Legion appreciates the hard work from all of the commission members and we look forward to working with this administration and the incoming Congress and administration to ensure veterans are provided with the high level of expert health care that they have earned.

Secretary McDonald's words on the report serve as a worthy stopping point for now: "However, until all veterans say they are satisfied, I won't be satisfied. Nobody at VA will be satisfied, but our progress so far proves that VA's current leadership, direction and momentum can produce the necessary transformation."

Conclusion

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org.

THE ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES

The Enlisted Association of the National Guard of the United States (EANGUS) was created in 1970 by a group of senior Non-Commissioned Officers. It was formally organized / incorporated in 1972 in Jackson, Mississippi, with the goal of increasing the voice of enlisted persons in the National Guard on Capitol Hill for enlisted National Guard issues. Beginning with twenty-three states, EANGUS now represents all 54 states and territories, with a constituency base of over 414,000, hundreds of thousands of family members, as well as thousands of retired members.

Headquartered and with offices in Alexandria, Virginia, EANGUS is a long-time member of The Military Coalition (TMC) and is actively engaged with the Guard/Reserve Committee, the Health Care Committee, and the Veterans Committee. EANGUS often partners with other National Guard related associations such as the National Guard Association of the United States (NGAUS), the Adjutants General Association of the United States (AGAUS) and the Reserve Officers Association (ROA) to pursue common legislative goals and outcomes.

EANGUS is a non-profit organization that is dedicated to promoting the status, welfare and professionalism of enlisted members of the National Guard by supporting legislation that provides adequate staffing, pay, benefits, entitlements, equipment and installations for the National Guard.

The legislative goals of EANGUS are published annually. The goals and objectives are established through the resolution process, with resolutions passed by association delegates at the annual conference. From these resolutions come the issues that EANGUS will pursue in Congress, the Department of Defense, and in the Department of Veterans Affairs.

President - Chief Master Sergeant John Harris, US Air Force Retired
Executive Director - Sergeant Major Frank Yoakum, US Army Retired
Legislative Director - Mr. Daniel Elkins

The Veterans Health Administration (VHA) Care System

Recommendation 1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access to high-quality health care services.

The Enlisted Association of the National Guard of the United States (EANGUS) recommends integrated, locally based health care networks that will take advantage of the current public and private health care infrastructure. These local networks will provide the aid necessary to serve their community's veterans and their health care needs. Furthermore, we recommend that the U.S. Department of Veterans Affairs (VA) remains the coordinator and guarantor of care for veterans. It is the VA's role to develop the systems necessary to equip veterans to make informed decisions on behalf of their health care needs.

While EANGUS supports the elimination of current wait-time and distance-based eligibility standards, we fully recommend that the VA remains the primary care provider for veterans when such care is readily available. When the VA is unable to be the primary care provider, veterans must be given the opportunity to present their personal preferences and needs to a VA health care professional in order to find a provider - whether they're private, public, or VA - that best suits them. This procedure would not only empower veterans to make informed decisions, but would also best utilize the networks within the VHA Care System.

We also recommend that the VA have the power to waive primary care referral for such specialty care like optometry and audiology that do not necessarily require a primary care consult.

And, while EANGUS is in support of a phased implementation of the VHA Care System that requires ongoing evaluation and management, we are not in agreement with Recommendation Nine. We recommend that the construction and integration of local networks be managed by a team of VA subject matter experts, receiving consistent guidance from local VA health care professionals and other Veterans Service Organizations.

Clinical Operations

Recommendation 2: Enhance operations through more effective use of providers and other health care professionals, and improved data collection and management.

EANGUS fully supports this recommendation to implement training programs for medical support assistants (MSA). MSAs will ensure that VA health care providers are able to spend more time actually treating veterans, rather than being tied down with administrative tasks.

In addition, the VA must also be able to keep up with the high turnover rates associated with MSAs and other entry-level positions at a local level. To do this the VA is currently implementing an expedited hiring process for MSAs as part of the MyVA transformation. EANGUS fully supports this initiative, but recommends that the VA have statutory authority to directly hire entry-level employees to fill high turnover positions.

Recommendation 3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

We support the recommendation to reform and enhance the current appeals process afforded veterans in order to mitigate disagreements between veterans and their health care providers, and to ensure that veterans obtain excellent and necessary medical attention.

Currently, veterans who disagree with their health care provider can appeal to that specific medical facility's chief medical officer. Veterans are only then able to appeal to their area's Veterans Integrated Service Network director (VISN), who rarely overturns a decision made by a medical center's chief medical officer. This decision by the VISN director is final unless veterans further appeal to the Board of Veterans Appeals. Given a time sensitive medical issue requiring immediate treatment, this is not an option, and veterans are left either untreated or subject to undesirable treatment plans.

Veterans have had vastly different experiences appealing clinical decisions within multiple VISNs due to the lack of a national, system wide appeals process. EANGUS is in favor of a systematic and dependable appeals process, and we strongly agree with the commission's recommendation to implement an interdisciplinary panel to revise the VA's clinical appeals process. This panel must safeguard veterans' ability to provide justification or evidence to support their appeals, which

many VISNs do not permit, and to have the ability to appeal clinical decisions above the VISN level.

Recommendation 4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

EANGUS is in agreement that the improvement of employee experience is an improvement to the VA health care system as a whole. When VA employees take pride in their work, they actively look for ways to improve the efficiency and productivity of their positions. However, there are not yet adequate processes for employees to identify problems or provide solutions. We support this recommendation to empower VA employees to identify and disseminate best practices, and to reward innovative employees who work to improve the care provided to veterans.

Health Equity

Recommendation 5: Eliminate health care disparity among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

EANGUS fully supports this recommendation. Health care disparities based upon social or economic status must be eliminated from the VA health care system. We have heard of women veterans being confused with and treated as caregivers or spouses, or having their veteran status being questioned because of their gender. All veterans must be treated with the dignity and respect they have earned and deserve, regardless of such difference as race, background, or gender.

We, therefore, strongly support implementing a cultural and military competence program throughout all VHA network providers and employees. It is crucial for veterans to receive informed care from health care providers who are aware their needs, and familiar with the health conditions associated with military service. This includes all VA health care providers as well as private providers within the integrated VHA network. The provision of cultural competence training will ensure that all veterans will receive care that is pertinent and tailored to their unique needs, and improve health care outcomes overall.

Facility and Capital Assets

Recommendation 6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital asset needs.

We mostly agree with the Commission's recommendations regarding the management of capital infrastructure. In order to streamline the VA's ability to enter into necessary leases, and to lease unused property more efficiently, we support waiving congressional rules requiring budgetary offset, and to expand enhanced-use lease authority.

We also are in agreement with the Commission that the ability to reevaluate the total cost of multiple, minor construction projects is necessary. But, we recommend the VA have the ability to umbrella multiple, minor construction projects under one contract, if these projects interdepend upon each other for completion. Furthermore, we suggest the implementation of differing classifications of major construction projects to ensure that the building of new medical centers does not conflict or enter into competition with facility expansions or seismic corrections.

The Commission recommends a new board to analyze and recommend changes regarding the needs of current infrastructure to include the development of the VHA's integrated health care system. But we at EANGUS recognize that most of the functions of this recommended board are already being carried out by the Federal Real Property Council (FRPC) and the Strategic Capital Infrastructure Plan (SCIP). We do not believe that adding another stage of bureaucratic process will solve an already inefficient system. Instead, we urge congress to grant the VA the full authority to close facilities, or certain departments within facilities, as they see fit.

We at EANGUS do not agree with the Commission's recommendation to realign the Defense Base and Realignment Commission (BRAC). Currently, the SCIP already deals with the issue of closing inefficient and dilapidated property, but as it has already been stated, they have been mostly ineffective and unable to prune the current infrastructure in order to promote efficient growth of the VHA network. Again, we urge Congress to grant the VA the authority to oversee and dismantle current VHA infrastructure as they see fit, as this is the most cost effective and timely way to dispose of out-of-date and inefficient facilities in order to make room for the continual improvement of VHA's infrastructure.

Furthermore, we urge Congress to explore means to create more partnerships between the VA and the Department of Defense (DoD), in line with the example set by partnerships formed between the VA and DoD in Chicago. Their model of partnership has proven to increase budgetary savings, expand available scope of care, and increase the access of care for servicemembers and veterans.

Finally, we encourage Congress to explore the model set by the National Guard in their continued pursuit to partner with local providers. The National Guard's model has improved the accessibility of care for servicemembers and veterans where DoD infrastructure is not yet in place, and such a model within the VA could continue to bridge the gaps in the VHA network to provide necessary health care for veterans until infrastructure can catch up to current needs.

Information Technology

Recommendation 7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

We at EANGUS support the Commission's recommendation to appoint a chief information officer (CIO) that focuses on efficient and strategic health care information technology (IT) in order to better serve the needs of the VA health care system. This CIO for the Veterans' Health Administration must work closely with VHA staff to efficiently implement IT systems that meet the needs of its users, and report to the Veterans Affairs' Assistant Secretary for Information and Technology LaVerne Council to maintain interoperability with the IT programs of the Veterans Benefits Administration and National Cemetery Systems.

We recommend that the VHA CIO have a multiyear budget that ensures health care programs are sufficiently supported and implemented.

We do not have a position on whether the VA should purchase a commercial, off-the-shelf, electronic health care system (COTS), or themselves develop an in-house electronic health care system. But, we strongly urge that the new electronic health care system be interoperable with the Department of Defense's Electronic Health Record system (EHR), regardless if it is a COTS product, or developed in-house. Investing in the interoperability of the VHA's and DoD's health record systems is the most cost effective and efficient solution. It will eliminate countless man-hour's squandered hunting down records for servicemembers and veterans, and it will ensure that no servicemember or veteran will ever be denied care because of inefficient and outdated bureaucratic recordkeeping.

Supply Chain

Recommendation 8: Transform the management supply chain in VHA.

EANGUS fully supports this recommendation that aims to reorganize and standardize the VA's supply chain. This will effectively leverage economies of scale, increase responsiveness and efficiency of the supply-chain, and reduce operating costs.

This recommended transformation of the management supply chain must rely on local feedback and their buy-in to be successful. So, while each individual medical facility will no longer be able to dictate where their supplies are purchased, there must remain the option to request specific supplies and products in order to provide the best quality care. We see this as similar to the already-existing non-formulary requests for prescriptions that are not on the VA's formulary. Lastly, this recommended transformation must evaluate whether specified requests are preferred or clinically needed by veterans, such as prosthetics.

Board of Directors

Recommendation 9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

EANGUS does not support this recommendation to establish a separate board of directors. We do not see current problems to be due to lack of management, but rather a lack of leadership in Veterans Affairs itself. This recommended governing board would be constituted of political appointees who, despite being health care executives, would not use the VA health care system. We do not believe that a separate board of appointees, having no real vested interest to improve the care and services for veterans, will outperform or better guide the VHA Care System transformation than improved leadership within the VHA itself.

Furthermore, we foresee that a governance board will not resolve the imbalance between capacity and demand that is pointed out in the Commission's report. It will instead introduce more bureaucracy, as this governing board would require yet an-

other step for the approval of VHA budget requests, which currently still have to be approved by the Office of Management and Budget and appropriated by Congress. Rather than limiting how much care the VA is able to provide, we recommend a reformation of the congressional appropriations process. We, therefore, urge Congress to empower the VA so that it does not need to lean on outside accountability measures in order to effect the changes necessary for the system to prosper, but allow the VA to resolve internal issues themselves. This will ensure that the VA receives its required resources more efficiently so as to better serve the health care needs of veterans.

Leadership

Recommendation 10: Require leadership at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

EANGUS is in full support of this recommendation. As previously discussed in Recommendation 4 and Recommendation 5, the continuous improvement of employee experience will not only sustain the transformation of the VHA health care system, but also work to restore and build up veterans' trust in their health care system.

Recommendation 11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

EANGUS strongly supports this recommendation. We believe in the importance of a systematic plan of mentorship, advancement, and succession, and we recognize the need for nationally structured programs that will recruit, develop, retain, and advance high performing leaders. Strong leadership development programs will empower VA employees to fill vacant leadership positions in the future, effectively building a nationwide leadership team of seasoned and invested employees to run VHA medical facilities.

Recommendation 12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

EANGUS is in support of this recommendation. We agree with the Commission that rapid growth within the VA central office and VISN network has weakened authority, blurred respective roles, and confused the boundaries of responsibility of each branch, impairing the VA's ability to meet veterans' health care needs. The implementation of clear boundaries and responsibilities to separate and focus the VA and VISN will empower all available resources within both organizations to accomplish their distinct and necessary purposes for the sake of the VHA.

Recommendation 13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

EANGUS generally supports this recommendation. We agree that it is important to implement an objective performance management system that can evaluate results throughout the VHA Care System, and to hold VA leaders accountable to implement improvements.

However, we do not believe the metrics of performance measurement must be identical to those used in the private sector. These metrics ought to borrow the best practices currently employed in the private sector, while also giving allowances for the singular mission of the VHA, and the differences between private and public health care systems.

Diversity and Cultural Competence

Recommendation 14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veterans' health outcomes.

EANGUS fully supports this recommendation. As stated in Recommendation 5, enhanced cultural and military competence training ensures the equity, improves the quality, and efficiently tailors the care that veterans' need. It is crucial for veterans to receive informed care from health care providers who are aware their needs, and familiar with the health conditions associated with military service. The better informed and prepared VHA network providers become, the more cost effective and efficient the provision of care becomes, thereby sustaining the VHA itself, and better serving the servicemembers and veterans in need.

Workforce

Recommendation 15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

EANGUS does not support this recommendation of the Commission. Currently, there are already two separate agencies attempting to coordinate as a personnel system in order to recruit, hire, train, and manage a competent workforce for the VHA. As things stand, the current laws and regulations governing how government employees are hired, paid, and disciplined are not adequate for the sustenance of a high performing health care system. However, we do not see the solution coming in the form of yet another system. This will only lead to further confusion and more bureaucratic steps that muddle the actual execution of hiring, paying, and disciplining a competent workforce.

EANGUS recommends, rather, a transformation of the current two-party system, where both USAJobs and the VA clearly demarcate their target demographic and untangle from each other. We believe that if Congress grants the VA with more authority to navigate its own hiring practices, it will streamline the netting and implementation of a capable workforce for the VHA, and resolve the current problems within the VHA personnel system.

Recommendation 16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

EANGUS supports this recommendation. As discussed above, we fully support the empowerment and higher call of leadership within the VA to implement changes and safeguard this process of VHA transformation. We urge Congress to continue to empower the VA to manage its own employees and resources more fully, thereby streamlining the process of stabilizing an effective human capital management system, and removing the hurdles caused by external agencies that slow down the VA from accomplishing its unique goals.

Eligibility

Recommendation 17: Proved a streamlined path to eligibility for health care for those with an Other-Than-Honorable discharge who have substantial honorable service.

EANGUS supports this recommendation to provide eligibility to veterans with Other-Than-Honorable discharges, given that they are combat veterans, and their overall service is deemed to be honorable.

Recommendation 18: Establish an expert body to develop recommendations for VA care eligibility and benefits design.

EANGUS supports this recommendation. We have seen that past evaluations and changes to eligibility criteria resulted in increased access to care for previously uncared for populations of veterans, and eligibility was realigned to match with updated delivery models. Recognizing that the implementation of an integrated health care system will change the model of delivering care, and having seen the benefits of evaluating eligibility criteria, we support the idea of an expert body to evaluate potential access barriers and current eligibility criteria, and to make recommendations to the VA based upon their findings, in order to ensure that service-connected, homebound, and disabled veterans run into no barriers or delays that would keep them from service and care.

IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Chairman Miller, Ranking Member Takano and Distinguished Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, thank you for the opportunity to share our views on the recently released Commission on Care Report. The Commission on Care was created by the Veterans Choice, Accountability and Access Law of 2014 and was charged with providing a framework for designing the Veterans Health Administration (VHA) for the next 20 years. IAVA appreciates the opportunity to have the voices of this nation's newest veterans heard as we discuss the long term future of veteran health care.

Overall the Commission on Care report has put forward thoughtful analyses and recommendations for reforming VHA. IAVA broadly agrees with many of the recommendations, but also has reservations with a few, which are outlined in detail in this testimony. Further, we have an overarching concern with the lack of consideration for how these recommended changes to VHA will impact the Department of Veterans Affairs (VA) as a whole, particularly VHA's ability to continue coordinating with the Veteran Benefits Administration (VBA) and National Cemetery Administration (NCA) as well as its ability to continue leading in health research and clinician training.

Regardless of the specifics of each recommendation, one thing is certain: Reforming VHA into a truly 21st century health care system will require significant coordination between VA, the larger administration, Congress, VSO partners, and the veterans we all serve. This coordination must be done in a bipartisan, veteran-centric manner that understands transformative change requires resources. IAVA encourages Congress to listen to the needs of the VA and fund any necessary changes at adequate levels without cutting existing critical benefits, like the GI Bill.

General Analyses

1. The report fails to consider how these recommendations to VHA will impact the VA as a whole, particularly VHA's ability to continue coordinating with the the VBA and NCA. One of the most unique aspects of the VA is its ability to offer wrap-around services to the veterans in its care. VHA is not only responsible for health care, but also oversees critical programs like suicide prevention and veteran homelessness. Over the years, the necessary coordination between VHA, VBA and NCA has continually improved. While not perfect, the cross-coordination of the these administrations is critical in maintaining VA's ability to provide these wrap-around services and fully support the veteran. This report does not address this critical need for coordination and how coordination would be impacted if these recommendations to VHA were implemented, but it must.

2. The report fails to analyze the impact of recommended VHA reforms on VHA's ability to conduct research and train future clinicians. Seventy percent of physicians receive some level of professional training from the VA. VA also trains over 20,000 nurses and nearly 35,000 people in other health related fields annually. This, combined with the robust research program that has led to groundbreaking discoveries in prosthetic development, spinal cord injuries, mental health injuries and burn care, expands VHA's impact in the community beyond any simple health care provider. These additional roles are critical aspects of the VHA footprint that were not accounted for in the development of the Commission on Care report. The impact of implementing these recommendations on these additional critical VHA roles must be taken into account.

3. The report does not acknowledge the challenges faced by VA due to the misalignment of demand, resourcing and authorities. The Independent Assessment of VA conducted by the Mitre Corporation found that a misalignment between demand, resourcing and authorities is one of the critical challenges of the VA to execute effectively on its mission. This report does not address this challenge. As the writers of the Independent Budget point out, at its current state VA is underfunded and cannot meet demand. Budget approval rests with Congress; only they can properly align demand and resources. And such substantial reform efforts, while needed, will require proper and realistic resourcing. IAVA would again echo our concern of recent Congressional efforts to pay for new services and benefits at the VA by cutting existing benefits and make a strong recommendation that this method not be used to fund transformative change within VHA.

4. The report is presented as a series of independent recommendations; it fails to acknowledge that the success of implementing a single recommendation likely depends on the execution of others and will also require extensive time and resources to execute effectively. The Commission on Care report puts forward a number of recommendations that will require time and resources to implement, and yet the challenges inherent to such a long-term, resource-intensive process are not addressed. Further, the report outlines a series of independent recommendations, but does a poor job of showing their interconnectedness. For example, an integrated network of care cannot be built without an up-

dated technology platform and infrastructure to support the network. Yet these, and the costs associated with them, are not mentioned in the recommendation to create an integrated network of care. This lack of integration gives a false sense of overall cost of implementing this plan. It also fails to emphasize that in many cases, if one recommendation is adopted without others, the overall plan to improve VHA will fail. It is critical to recognize that while these recommendations are presented as stand-alones, many will be intertwined and one cannot be fully achieved without others.

5. The report failed to take into account reforms and programs that the current VA Secretary has already planned and/or implemented. The Secretary conducted an extensive internal assessment of the VA when he was initially appointed to the position in 2014. As a result, he has put into action the myVA initiative, which addresses many of the points raised by the Commission on Care report. The report does not specifically address this initiative or take under consideration potential redundancies of the recommendations of the Commission report.

6. The report recommendations are broad, contradictory at times, and can be left somewhat open to interpretation. This presents a challenge as leadership and the makeup of Congress changes. The broad and contradictory nature of the report does not provide clear and concise direction and the intent of the Commission in making these recommendations might be lost to political leanings.

Analyses of Report Recommendations

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as VHA Care Systems, from which veterans will access high-quality health services.

IAVA Analysis: IAVA recognizes that the VA cannot fulfill its mission alone and a fully integrated network of care that includes community providers will be essential to achieving this mission. We also agree with the need for an integrated model that requires patients to consult with a primary care provider to receive specialty care services and removes the arbitrary eligibility criteria enacted by the Choice Program. However, we disagree with primary care services being available outside of the VA, even if it is limited to within the community network. While well-intentioned, IAVA is concerned that a broad interpretation of this recommendation creates a framework whereby VHA as an institution can slowly be phased out. Furthermore, IAVA is not convinced the primary care providers outside the VA could effectively treat the whole veteran and effectively help veterans navigate the VA. A veteran's primary care provider needs to be the quarterback of their care; they've got to be central and fully integrated into the team.

Additionally, the budget assessment for this recommendation makes a number of assumptions that may or may not hold true. First, the economic analysis does not include cost assessments for upgrading the IT platforms to support a truly integrated network, costs associated with the needs of the physical infrastructure of facilities nor additional administrative costs to support this new model.

Although not specifically addressed, this recommendation also assumes that community providers will be available and able to absorb the demand created by integrating this network. The model estimates as much as 60 percent of VA care shifting to the community network (from 34 percent currently). This will likely create a large demand on a community medical system already struggling to meet the demand of existing civilian patients (a challenge already realized by VA Choice providers). Finally the implementation of such a system does not take into account the impact on research and training, and could have a severe negative economic impact if not mitigated.

Overall, IAVA supports an integrated network of care that includes community providers, with integration of VA primary care providers managing the patient care and an overall resource estimate that considers additional costs needed for administrative support, IT systems and infrastructure required to support the network. We find this recommendation well intentioned, but too broad, lacking critical pieces of analysis, and with a fatal flaw: the external primary care provider.

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, improved data collection and management.

IAVA Analysis: There is a growing shortage of physicians and the health care community will need to be open to expanding responsibilities for all health professionals. IAVA agrees with the need for VHA to more effectively engage its professional staff and ensure that clinicians have the support staff, both clerical and clin-

ical, they need to use their time more efficiently and effectively to treat patients. We also agree that data integrity and collection must be a priority.

Recommendation #3: Develop a process for appealing clinical decisions that provides the veterans protections at least comparable to those afforded under other federally-supported programs.

IAVA Analysis: IAVA has no strong opinion on this recommendation. IAVA does support the intent to convene an interdisciplinary panel to further assess and offer recommendations regarding revising the clinical appeals process to ensure the veteran is receiving a judicious and uniform process when appealing a clinical decision.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

IAVA Analysis: IAVA has continually recognized that one of the challenges at VHA is sharing best practices across the VHA system of care. Under the leadership of Secretary McDonald and the Undersecretary for Health, Dr. Shulkin, VHA continues to try and identify innovative solutions at the local level and bring these to the greater VHA community. However, streamlining these practices has been a challenge. We concur with the intent of this recommendation, VHA must establish an effective way to identify these transformative programs and share them across the VA in a streamlined and efficient way. However, we are not confident that the Veterans Engineering Resource Center is the appropriate entity to meet this intent.

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the cause of the problem and ensuring VHA Health Equity Action Plan is fully implemented.

IAVA Analysis: IAVA agrees that VHA should adopt as a primary mission the elimination of health care disparities among the veterans it serves. As the report states, minority populations are growing in the U.S. as a whole, and also within the veteran community. For VA to fully recognize its mission to serve veterans, it must be focused on serving all veterans.

IAVA has recently focused on improving services to women veterans. Women veterans are a minority group, but they are not homogeneous. Women veterans are a very diverse population. We agree with the report's findings that the VA prioritize and fully resource serving minority populations. Additionally, we agree that while VA has improved its focus on understanding these populations through research, more must be done. There is an overall lack of data on vulnerable populations and a lack of data on how VA is doing to support these populations. This data gap must be closed. In doing so, VA will have the tools to finally address the needs of these populations in a data-informed way.

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

IAVA Analysis: As the Commission on Care report recognizes, the VHA infrastructure is in dire need of attention. The average facility is 50 years old, resources for updates are nowhere near adequate and the ability for VA to conduct needs assessments of its facilities and act on those assessments are hindered by Congressional oversight. IAVA agrees that the VA must have more flexibility to meet its facility needs. We also recognize the growing importance of ambulatory care needs, while balancing the availability of inpatient facilities.

Additionally, we feel it is imperative to recognize the current challenges for VA to enter into agreements with health care partners to share space, equipment or personnel. Current law makes it nearly impossible for these private-public partnerships to be entered into, and in order for VA to implement recommendation one of this report, an integrated network of care, this capability is essential.

IAVA also agrees that there could be resources gained by empowering VA to make these critical facilities decisions. There are a number of legislative changes that can be made to address the critical infrastructure needs of the VA. It will be imperative that Congress work with the VA to make these needed changes a reality.

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business practices.

IAVA Analysis: IAVA recognizes the VA IT system will be a critical component of an integrated system of VA care. Currently, the IT system is woefully outdated and does not afford the possibility of this integrated system. The current care in the

community programs and providers do not interface with VA in a streamlined manner, making care disjointed. Further, the report points out that a lack of standard clinical documentation and a standardized electronic health records (EHR) across all facilities makes record sharing across facilities and from facility to veteran very difficult. IAVA agrees with these findings. In order for VHA to provide a streamlined, high quality and timely level of care, the IT system must be brought into the 21st century. VHA must have a detailed strategy and roadmap to achieve this level of IT and it will require the support of Congress to fulfill its vision.

IAVA has advocated not only for an update to the VHA IT system, but also the development of an interoperable EHR between Department of Defense (DoD) and VA and within VA. This is critical to providing patient service to the military/veteran population. It is also required by law and past due. However, with an integrated network, the need for interoperability will go beyond the VA and DoD and include its community partners.

We are concerned that the priorities of VHA's IT needs are getting lost in the Office of Information and Technology and agree VHA needs an IT advocate working to meet the IT needs of VHA. However, we believe this would also benefit VBA and NCA and they too should have IT advocates.

Finally, we agree that the budget cycle as it stands now makes it very difficult for VHA to plan for and execute on IT needs, and concur that VHA's IT budget needs should also be on a two year cycle with VHA's advance appropriations cycle.

Recommendation #8: Transform the management of the supply change in VHA.

IAVA Analysis: This is beyond the scope of IAVA's expertise and therefore we take no position. However, we support any mechanisms that could improve efficiencies and allow for resources to be reallocated elsewhere in VHA with these improved efficiencies.

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy and direct and oversee the transformation process.

IAVA Analysis: IAVA understands the reasoning behind this recommendation and agrees that continuity in leadership is critical to long term reform. However, it can be very difficult to impose private sector practices (Board of Directors) on a public sector entity (VHA) because of the nature of that public sector entity.

In an attempt to increase accountability in VHA, establishing a board runs the risk of the opposite effect. Particularly with the establishment of the board through various political appointees, the board risks becoming another entity where inaction becomes the norm because of opposing viewpoints. Additionally, as described the board has no fiduciary control; Congress will continue to be the final oversight authority. IAVA is concerned that the addition of the board adds another layer to the already burdensome bureaucracy. A board of directors without fiduciary responsibility effectively becomes an advisory board, and VA already has one, and arguably multiple, of those established through the myVA Board and the VSO community.

We understand the Commission's concerns over continuity of senior leadership roles such as the Undersecretary of Health and are willing to consider a longer term of appointment for the Undersecretary of Health, but believe that this requires further analysis on the impact on VBA and NCA. More generally, with a change in governance structure such as this recommendation, there must be considerations as to how this impacts the coordination between VHA, VBA and NCA.

There is also further consideration to be made as to the role that VSOs, Congress and other informal advisors already play in this capacity.

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to reform VHA culture and sustain staff engagement.

IAVA Analysis: As the report recognizes, the cultural and organizational health of VHA must be positively transformed before the VHA can function at its greatest potential. IAVA strongly agrees that in order to build a healthy culture, VHA must instill greater collaboration, ownership, and accountability among its employees. We applaud the strong dedication found among VHA employees and continue to advocate for policies and opportunities that best strengthen and support the VA's workforce.

We agree with the report's recommendations that stress a systems-oriented, leadership-supported, and flexible approach to cultural transformation. However, IAVA is concerned that this cultural transformation must be conducted throughout all of the VA and not exclusively siloed within VHA. Given the strong inter-agency co-

operation at the VA and the need for VA leadership at its highest levels to support these goals, implementing the changes suggested by the report must be done across the whole VA.

Additionally, the concept of the transformation office has the potential to help drive and focus the suggested cultural changes. However, we would need to understand the specifics of how the transformation office would function, how it would disseminate policies and training, and how it would be able to support local and national change to understand if such an office would be a more effective model of change than the current system. Since the report also directs this new transformation office to report directly to the suggested governing board, we would echo here our concerns detailed under the analysis of recommendation nine.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

IAVA Analysis: IAVA overall agrees that VHA does not have a strong plan in place for leadership development and growth and this is critical for the continued success of VHA. Under Secretary McDonald, the need for leadership development has been recognized and is one of many areas where IAVA is excited to see progress already being made.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

IAVA Analysis: IAVA supports streamlining VHA and empowering staff to make decisions, but in empowering the staff VA must ensure they have the right tools and metrics to make informed decisions. IAVA supports reducing redundancies and simplifying organizational structure, but also want to ensure that in simplifying vital processes are not lost.

We have also supported the VA Secretary's request for more budgetary authority to make these critical decisions and route resources to where the need rests. We understand the need for a health care system to have that additional flexibility, but that must be carefully balanced with ensuring vital programs continue to be funded.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

IAVA Analysis: IAVA broadly agrees with the need for VHA to streamline and focus its organizational performance measures and establish the same in a personnel performance measure system. These metrics must be clearly defined, measurable, and speak more to the need for meaningful measures tied to safety, quality, patient experience, operational efficiency, finance and human resources (as indicated in the Independent Assessments). We also see value to tying these metrics to private sector measures given recommendation one to create and integrate the network of care, but hesitate to rely too much on the private sector measures given that VHA also has its own unique aspects that might warrant some measures outside of the private sector. Additionally, this is another area being addressed by the VA Secretary's myVA transformation plan.

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers and staff to embrace Diversity, promote cultural sensitivity and improve veteran health outcomes.

IAVA Analysis: IAVA completely agrees that military cultural competence is critical for all who provide care to veterans. A recent RAND report that looked at military cultural competence among community mental health providers defined this not just as knowledge and comfort with the military culture, but also knowledge of evidence-based practices to treat mental health injuries and ability to practice these techniques. It's critical to recognize that competence applies at all levels, from the individual greeting as the veteran walks in the door, to the provider treating the patient. All VA staff must be trained in this. Additionally, providers and their support staff must understand the specific health indicators for this population to better serve them. IAVA supports all of the recommendations in this section specific

to asking about military health history and awareness of all veteran groups, including providing quality care for women veterans and the LGBT community. This will be a critical requirement for any community providers that are adopted into the VHA network, whether it be the current care in the community programs, or some future iteration.

Recommendation #15: Create a simple to administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management and supports pay and benefits that are competitive with the private sector.

IAVA Analysis: IAVA is an active advocate for a dedicated focus on VA staffing. Specifically at VHA, we agree that attracting talent to VHA will be critical at all levels of the staffing hierarchy, and so competitive salaries and hiring incentives will be critical in doing this, as well as expediting the hiring process. We also recognize the tradeoff of moving from a Title 5 to a Title 38 hiring structure, including potential impacts on the diversity of the hiring pool. We recommend that should this recommendation be considered, this concern be addressed and then monitored if the recommendation is implemented. Given that VA serves a unique and diverse population, we want to be sure that the staff that serves this population maintains that same diversity.

We also agree that VA HR should take a more proactive approach in developing leaders within VHA. We encourage VA to consider how VA HR can balance the needs to meet regulatory requirements, but more importantly emphasize professional development and fostering leaders among the VA ranks, as well as improving morale and hopefully as a result, retention.

Any discussion on improving VA personnel systems must also include a discussion on increasing accountability at the VA. While a vast majority of VA employees serve veterans in an exemplary way, there are also those who discredit the VA through underperforming or plain negligent acts. Being able to jettison these employees in an expedited manner while also protecting whistleblowers and rewarding those that do serve in an exemplary way are the keys to restoring VA morale.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds and assign expert resources to achieve an effective human capital management system.

IAVA Analysis: In order to achieve recommendation 15, recommendation 16 must also be a priority. To reform the personnel hiring and HR administrative systems, leadership must be in support and must prioritize it.

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

IAVA Analysis: IAVA agrees with this recommendation. Those with Other-Than-Honorable (OTH) discharges can be among the most vulnerable in our veteran population. They are at a higher risk for suicide and homelessness, and often as a result of their discharge status may have no VA resources available to them. Community programs often mirror the eligibility criteria of the VA, and so even these resources may not be available to them. They become stuck in limbo, possibly needing help for an injury sustained while in service, but not able to obtain that help because they are not eligible due to their discharge status. For some, the injury obtained during service might have even contributed to the OTH discharge received.

Awarding temporary eligibility to these individuals will allow for access to critical services without delay in health care due to the current process for determining eligibility. However, it's important to stress that with this change will be a resource burden on the VA that will require Congress to support. With increased demand comes increased need for resources.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

IAVA Analysis: This remains a critical issue within the veteran community and updates to VA eligibility have not been addressed in 20 years. It is past time to do so. IAVA agrees with the recommendations to form a body to review these criteria and develop recommendations to meet the needs of all veterans.

Again, IAVA appreciates the opportunity to outline our review of the Commission on Care. Change is necessary, and working together we know the VA and the health care it provides can be strengthened to provide the highest quality care for veterans in this nation's history. IAVA looks forward to continuing to work alongside this

Committee, Secretary McDonald and our fellow VSO partners to evaluate and implement changes necessary to best achieve this goal.

MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN MILLER, RANKING MEMBER TAKANO, and Members of the Committee, the Military Officers Association of America (MOAA) is pleased to present its views on the Department of Veterans Affairs (VA) Commission on Care Report under consideration by the Committee today, September 7, 2016.

MOAA does not receive any grants or contracts from the federal government.

EXECUTIVE SUMMARY

On behalf of our 390,000 members, MOAA appreciates the Congress' vision in establishing an independent commission to look at how best to organize and deliver health care in the VA Health Administration (VHA) in the 21st Century.

After reports of secret waiting lists at the VA medical center in Phoenix, Arizona, MOAA urged President Obama to establish an independent commission in order to make immediate and long-range systemic changes necessary to provide the best quality care and support services to our Nation's servicemembers, veterans and their families.

After 10 months of intense deliberations, public meetings, testimony, and extensive inputs from experts across the country, including MOAA, the federally-directed Commission on Care issued its final report on June 30, 2016.

MOAA was particularly grateful for the open and collaborative process commissioners established in order to receive information, feedback and viewpoints from veterans themselves, as well as from veteran and military service organizations representing this constituency.

Overall, MOAA supports most of the Commission's findings, and we are pleased to see many of the report recommendations incorporate the changes Secretary McDonald and veterans service organizations (VSOs) have been advocating for since the implementation of the Veterans Access, Choice and Accountability Act of 2014 (Choice Act).

While much more remains to be done, we appreciate the Commission's sincere effort to strike a balance of sustaining and improving VA health care delivery while enhancing civilian care opportunities.

Along with our VSO partners, we look forward to working with the President, Congress and the VA to translate the Commission's recommendations into effective action.

The following section provides MOAA's views and concerns on selective issues and recommendations for your consideration.

COMMISSION ON CARE REPORT ANALYSIS AND RECOMMENDATIONS

MOAA believes Chairperson Nancy Schlichting's statement on the final report released on July 5, 2016, is an excellent characterization of the current system and provides a compelling reason for why immediate reform is needed.

"The system problems in staffing, information technology, procurement and other core functions threaten the long term viability of VA health care system and that key VA systems do not adequately support the needs of 21st century health care," stated Schlichting, CEO of the Henry Ford Health System. "The Commission found that no single factor can explain the multiple systemic problems that have frustrated VA efforts to provide veterans consistent timely access to care. Governance challenges, failures of leadership, and statutory and funding constraints all have played a role. As the Final Report states, however, 'VHA has begun to make some of the most urgently needed changes outlined in the Independent Assessment Report (Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Report, published January 1, 2015), and we support this important work.'"

MOAA supports the following key elements of the report recommendations:

Redesigning the Veterans' Health Care Delivery System

- Establish high-performing, integrated community-based health care networks to be called "VHA Care System (VCS)" to include VA facilities and Department of Defense (DoD) and other federally-funded providers and facilities.

- VCS networks retain existing special-emphasis resources and specialty care expertise (e.g., spinal cord injury, blind rehabilitation, mental health, prosthetics, etc.).
- Community providers must be credentialed by VHA to qualify to participate in community networks, ensuring providers have the appropriate education, training, and experience.
- Highest priority access to health care would be provided to service-connected and low-income veterans.
- Eliminate the current time and distance criteria for community care access (30 days/40 miles).
- VCS should provide overall health care coordination care and provide navigation support for veterans.
- Veterans would choose a primary care/specialty care provider in VCS-specialty care requires referral from the primary care provider.
- VHA should increase efficiency and effectiveness of providers and other health professionals by improved data collection and management, adopting policies to allow them to make full use of their skills.
- Eliminate health disparities by establishing health care equity as a strategic priority.
- Modernize VA's information technology (IT) systems and infrastructure.

While VA alone cannot meet all the health care needs of veterans, the system does provide for a foundational platform upon which to build. The Commission acknowledges the importance of this foundation up front in the report:

"VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement."

MOAA believes the new health care system delivery model needs to preserve well-known programs and competencies in VHA's mission areas of clinical, education, research, and national emergency response—all critically important elements and capabilities integrally linked to the broader VA mission as well as the American medical system.

The report does note however, that while care delivered in VHA in many ways is comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility because of operational systems and processes, access, and service delivery problems.

Specialty programs and resources are unique and distinctive capabilities which set VHA apart from the private sector in its ability to deliver critical and specialized medical services. This is particularly true in the areas of behavior health care programs, integrated behavioral health and primary care through its patient-aligned care teams, specialized rehabilitation services, spinal cord centers, and services for homeless veterans—core competencies and capabilities which should be expanded, enhanced, and shared across government and private sector health systems.

These unique medical capabilities, combined with other government (DoD and other federal health systems) and private sector partners to create high-performing networks of care, would allow VHA to more effectively assimilate its system of care through integrated community-based health care networks of the VCS. Such change would result not only in greater system optimization, but also better serve our veterans.

MOAA is pleased the Commission recognized VA's primary overall role in coordinating health care and helping veterans navigate the system whether care is delivered in VA medical facilities or through community providers. Though the new system would allow veterans the option to choose a primary care provider (PCP) from all credentialed PCPs across the system, and all PCPs would be responsible for coordinating veterans care, MOAA believes VA must retain ultimate responsibility for veterans' health care and managing health information and patient outcomes to ensure quality and continuity of care and services.

Like many VSOs, we support the elimination of the current time and distance criteria for community care access (30 days and 40 miles). Implementation of the Choice Act using the current restrictive and arbitrary eligibility criteria has created problems that require a fresh look at what the standards should be in the new VA health system.

MOAA is also supportive of refocusing health care benefits to allow service-connected, disabled and low income veterans' higher priority. Additionally, VHA must eliminate existing health disparities by making health care equity a strategic priority. The report outlined a number of racial and ethnic health inequities in the sys-

tem. More must be done to institutionalize cultural and military competency and eliminate system disparities as we move forward in the transformation.

Similarly, MOAA agrees with the Commission's approach to allowing health care providers and professionals such as advanced practice registered nurses to work to their full licensure potential. This is already being done in many states and government health agencies, including the Defense Department, and offers a positive solution for addressing VHA's suboptimal productivity levels. MOAA has strongly advocated for such change as a means to help expand current system capacity and capability.

Further, the report highlighted the need for VA to invest in transforming its antiquated, disconnected IT systems and infrastructure to improve veterans' health and well-being. MOAA agrees such an investment in a comprehensive electronic health care information platform is foundational to VA's ability to establish, operate and sustain a health system equal to or better than what is found in the private sector.

This platform must be interoperable with other systems within the network, enabling scheduling, billing, claims, and payment. It should be easy for veterans to access their own information so they can better manage their health. Years of underfunding VA IT and financial management clinical, administrative, and business systems has prevented VA from evolving and innovating to remain relevant and agile as private sector medicine and patient health needs change over time.

Governance, Leadership, and Workforce

MOAA agrees with Commission recommendations to:

- Develop and implement a strategy for cultural transformation.
- Reform and modernize VA's leadership and human capital management systems to recruit, train, retain, and sustain high quality health care professionals and executive-level leaders.
- Create a simple-to-administer alternative personnel system.
- Transform the organizational structure of VHA and reengineer business processes.

Cultural transformation across the VA enterprise is imperative and it starts at the top with effective leadership. VA's last major transformation occurred in the mid-1990's. Former Under Secretary of Veterans Health, Dr. Kenneth Kizer told commissioners, "Today's VHA is intensely, unnecessary complex, and lacks a clear strategic direction, and is hampered by overly top-down management at VA's Central Office (VACO), where the staff size more than doubled in a five year period between fiscal years 2009 to 2014 as a result of centralizing a portion of field operations functions to VACO."

Of all government agencies, VHA has one of the lowest scores in terms of the organizational health and has repeatedly appeared on the Government Accountability Office's (GAO) high-risk list. GAO has documented well over 100 outstanding systemic weaknesses covering a wide-range of management and oversight problems in the VA health care system, including insufficient oversight of employees and leadership.

While the VA has a reputation for having a highly dedicated staff focused on serving veterans, VHA is often perceived by employees as being very bureaucratic, driven by politics and crisis, and having a risk-adverse culture, with little connection to leadership. These findings from the Independent Assessment are persistent and prevalent across the system even though VA has undertaken a number of initiatives in recent years to address the culture of the environment.

MOAA agrees with the Commission's recommendation to create an integrated and sustainable culture of transformation where all programs and activities are aligned, and leaders at all levels of the organization are responsible and accountable for improving organizational health and staff engagement.

Such transformation must also include reforming and modernizing VA's leadership and human capital management systems across the enterprise. Currently VHA lacks a comprehensive system for leadership and employee development and urgently requires a workforce management and succession planning strategy for attracting, training, retaining, and sustaining high quality health care personnel and executive-level leaders.

MOAA urges the Committee to support improvements to the Department's leadership and human capital management systems by providing the necessary funding and authorities needed to implement the report recommendations. The VA needs the financial incentives and hiring authorities to attract outside leaders and experts who want to serve in VHA, to include temporary and/or direct hiring of health care management graduates, senior government and private sector health system leaders

and experts to stabilize the current workforce and to remain competitive in the health care market.

Additionally, VHA must embrace a systems approach to transforming its organizational structure and reengineer business processes to align with the VHA mission, eliminate unclear, duplicative functions, and clarify roles and responsibilities at VACO on down to field offices and medical facilities. VHA needs a more simplified organizational structure, performance measurements, and processes for business operations—the current operating system is unnecessarily complex, confusing and cumbersome.

The Commission proposes one model for streamlining VHA structure to reflect the structure used in large private-sector hospital systems. MOAA believes this should be a priority to eliminate duplication, consolidate program offices, and create a flatter and more sustainable structure.

Eligibility. MOAA agrees with the Commission proposal to establish an expert body to develop recommendations for VA care eligibility and benefit design.

The criteria for determining health care eligibility has not changed in 20 years even though VA's health system has seen tremendous change during this time. Current criteria are outdated and confusing to veterans and VHA staff and are inconsistently administered across the system.

The report also spotlighted “that nothing in law or regulation assures service-connected, disabled veterans of priority of care.” The new system must assure priority to these as well as other vulnerable segments of the veteran population.

Major Areas of Concern

MOAA has some concern about Commission proposals to:

- Establish a Governing Board of Directors to provide overall VCS governance, set long-term strategy, and direct and oversee the transformation process.
- Provide a streamlined path to eligibility for health care for those with Other-Than- Honorable (OTH) Discharge who have substantial honorable service.

The Commission recommends an 11-member board which would be accountable to the President, having decision-making authority to establish long-term strategy and implement and oversee the transformation of the new health system.

The Board of Directors would also provide recommendations to the President for appointment of a Chief of VHA Care System (CVCS) for a five-year term (could be reappointed for a second term). The CVCS would report to the Board and function as a chief executive officer of VHA. The idea is to provide longer-term continuity in VHA operations and prevent disruption in leadership that often comes with political transitions.

As with many of our VSO partners, MOAA supports the concept of a longer-term appointment for the Under Secretary of Health to ensure continuity when changes in leadership occur in the Executive and Legislative Branches, but would not be supportive of establishing a Board of Directors. MOAA believes Congress' role of oversight is essential in holding VA accountable in caring for veterans, and Congress must continue to be veterans' strongest advocate. Establishing a Board of Directors would usurp Congress' role, add an additional level of bureaucracy, and in our view, likely slow progress and hinder transformation.

Finally, the Commission recommends VA revise its regulations to provide tentative health care eligibility to former servicemembers with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances (e.g., traumatic brain injury or post-traumatic stress that likely contributed to their OTH discharge).

MOAA understands the Commission's concern about VA's strict interpretation of what is truly dishonorable service and agrees the ambiguous and subjective application of regulations resulted in disparities in adjudicating veterans' cases. MOAA has supported establishment of boards to review and upgrade discharges in such cases where appropriate. VA estimates there are over 700,000 OTH cases, and it would cost upwards of \$846 million to implement the Commission's recommendation, but acknowledges the true size of the population and costs are unknown.

VA also acknowledges the need to streamline the Veterans Benefits Administration's characterization of discharge adjudication process when veterans apply for benefits. The current process is not standardized and is taking far too long for decision-making, preventing veterans from getting the care they need sooner rather than later. While VHA has established partnerships with community organizations to help link non-eligible veterans to care outside the system, more needs to be done to address these disparities. MOAA recommends Congress direct VA to provide more information on the current scope of the problem, potential costs and the impact on VHA of such changes before implementing the Commission's recommendation.

CONCLUSION

MOAA appreciates Chairman Miller's response to the report in a July 6, 2016, Washington Post article by stating, "The report makes it abundantly clear that the problems plaguing the VA medical care are severe. Fixing them will require dramatic changes in how VA does business, to include expanding partnerships and community providers in order to give veterans more health care choices."

MOAA is confident that collectively we can achieve dramatic transformation in VHA which will serve our Nation, veterans and their families for decades to come. While it will take a significant commitment and investment by government and non-government communities, we believe reform is possible and achievable. Our veterans and their families deserve no less.

MOAA thanks the Committee for considering the important findings and recommendations in the report. Our organization looks forward to working with the Congress, the VA and the Administration to reform and modernize the VHA system of care.

NOVA

September 6, 2016

The Honorable Jeff Miller
Chairman
House Committee on Veterans' Affairs
345 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Miller:

On behalf of the over 3,000 members of the Nurses Organization of Veterans Affairs (NOVA), we would like to offer our thoughts regarding the Commission on Care Final report being discussed before your Committee today.

NOVA thanks the Commissioners for their hard work and believes many of the recommendations offered will improve the care we provide veterans every day at VA facilities around the country. Recommendations to include providing additional resources to modernize IT, increase HR and other support staff, strengthen capital assets and recruit and retain a high quality professional workforce, all have our support.

The most glaring recommendation - and one that has received strong opposition from veterans' advocates and those in the community working to care for veterans - is a proposal that would create a VHA Independent Board which would govern the VA health care system.

NOVA strongly opposes giving an outside board - made up of civilian health care executives who may have never set foot into a VA facility - the authority to make decisions about the care and services provided America's veterans. Creating another layer of bureaucracy, which would take VA's ability to manage care away from those who are held accountable by this very body seems ill-advised. Oversight for veterans' health care handed over to a newly created external board would all but dismantle the most effective and innovative features of the current VA system - the Primary Care/Mental Health Integrated approach. It also fails to take into account the many wrap around services that VA offers veterans, while ironically recognizing that VA provides better coordinated care than any of its private sector partners.

NOVA agrees in order to reform VA so it can best serve our nation's veterans, we must expand access to services that it currently provides by hiring at VA facilities where demand exceeds available staffing, where geographic challenges exist, and specific services are not offered, allowing veterans the option of using purchased care available through its community providers.

Community providers should be a crucial part of the integrated network of care, but VA must remain the first point of access and coordinator of all care. As nurses, managing workflow and coordinating care is key to providing the quality that serves as a model for VA's "whole health" approach to care.

NOVA asks that any discussion regarding the Commission's proposed recommendations to improve gaps in service be made in a thoughtful, transparent process and involve all stake holders. Preserving an integrated health care community designed to put veterans first must include VA. It is VA care that veterans overwhelmingly prefer and deserve.

Sincerely,

Sharon Johnson, MSN, RN, President
Nurses Organization of Veterans Affairs

PARALYZED VETERANS OF AMERICA

Chairman Miller, Ranking Member Takano, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to express our views on the Commission on Care's Final Report. We appreciate the Committee's continued commitment to thoroughly examining the best way forward for comprehensive reform in the delivery of veterans health care.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: *Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.*

PVA supports the creation of fully integrated health care networks with the Department of Veterans Affairs (VA) maintaining responsibility for all care coordination. This part of the recommendation is consistent with the proposal that PVA along with our partners in The Independent Budget (IB)-DAV and VFW-put forward late last year. We also support eliminating the 30-day and 40-mile standards for access established as part of the Choice program. The IB offered a similar recommendation last year suggesting that access to care and when and where to seek service should be a clinically-based decision determined by the veteran and his or her provider, not an arbitrary access standard. Despite our support for the concept of creating fully integrated health care networks, we have some significant concerns with other aspects of the Commission's recommendation.

We are first, and foremost, concerned with the Commission's recommendation for "choice." The report proposes that veterans should have unrestricted choice for any primary care provider within their newly-constructed network. In order to access specialty care (outside of VA's specialized services), veterans would be required to get a referral from their designated primary care provider.

The Commission does not, however, discuss what the boundaries should be in establishing the networks. The breadth of the networks is limited only by the Commission's assumption that the networks will be "tightly managed" by VA and that primary care providers wishing to participate will meet certain quality standards. Together these two parameters do not establish a clear picture as to what extent VA may efficiently dilute its capacity to deliver care in favor of outsourcing to the private sector.

These networks must be developed and structured in a way that preserves VA's capacity to deliver high-quality care while specifically preserving its core competencies and specialized services. Without a critical mass of patients, VA cannot sustain the very infrastructure that supports and makes VA specialized services world-class. Providing veterans unfettered choice as to their provider jeopardizes this baseline of patients. A better proposal is found in VA's Plan to Consolidate Community Care Programs, which rests on a principle of using community resources to supplement service gaps and better realign VA resources. This sets a natural boundary that would prevent the networks from expanding to a harmful and unmitigated degree. Ultimately, the Commission failed to articulate what constitutes a "tightly managed" network, and it admittedly did not contemplate "[r]eductions in the volume of care within VA facilities, and potentially adverse effects [on] quality" ¹ The result we are left with is lip service paid to preserving VA's specialized services.

In addition to VA specialized services, there is insufficient discussion regarding care coordination within these networks. The recommendation suggests that care coordination take place through all primary care providers, but VA would assume overall responsibility for care coordination of all enrolled veterans. There is no delineation, though, as to exactly where VA and community providers hold responsibility. The recommendation is conflicting and could ultimately lead to finger pointing instead of well-coordinated care for veterans being served in the community. We

¹ Commission on Care, Final Report, June 30, 2016, p. 32 (hereafter "Report").

would again point to VA's Plan to Consolidate Community Care Programs.² VA's proposal would administer care-coordination based on the intensity of coordination needed. This method offers the functionality and flexibility needed to ensure that patients with complex cases receive adequate attention and resources. It also tailors the level of care coordination to each individual patient's complexity and needs, regardless of whether the patient receives care in VA facilities or in the community.

We are further concerned with the report's consideration of funding for the new health care delivery system. It does not clearly reconcile how VA currently determines its appropriations needs through the Enrollee Health Care Projection Model (EHCPM) with how it will have to determine its appropriations needs through the new system with local leadership input.

The report also considers cost-sharing, particularly for veterans with non-service connected disabilities. The cost-sharing opportunity would be used to expand options for choice, but it would likely come with increased costs for Priority Group 4 (non-service connected catastrophically disabled) who do not currently have a cost for their care. This proposal is contemplated within the larger context of determining priority of service. The report recommends priority be given to service-connected disabled veterans and those with low incomes, but it does not properly consider the relationship of Priority Group 4 veterans to the system.

Finally, as VA begins to involve community providers at a greater rate, it is essential to ensure that the process for adjudicating medical malpractice claims is the same whether that care was received in the community or within VA. In almost all cases, the current process under 38 U.S.C. §1151 treats malpractice claims the same regardless of where they received care. However, certain unique situations still present inequitable results for veterans.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

PVA generally supports this recommendation as it would allow providers in the VA health care system to practice within the full scope of their licenses. The report also addresses bed capacity reporting as originally established by P.L. 106–117, the “Veterans Millennium Health Care and Benefits Act.” It appears to endorse a requirement for VA to report beds as closed, authorized, operating, staffed, and temporarily inactive.

We reiterate our support for reinstating the capacity reporting requirement originally established by P.L. 104–262, the “Veterans’ Health Care Eligibility Reform Act of 1996.” VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans. Reductions in both inpatient beds and staff in VA’s acute and extended care settings have been continuously reported throughout the system of care, particularly since the capacity reporting requirement expired in 2008.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-funded programs.

PVA supports this recommendation as it aligns VA with widely accepted medical practice. As it stands, each Veteran Integrated Service Network (VISN) has its own process for appealing clinical decisions. Failure to standardize the appeals process across VA naturally produces a disparity in outcomes among similarly situated veterans seeking to bring clinical disputes. Furthermore, external review of final VA decisions is subject to the discretion of the VISN director.

One aspect of current VA policy that is not addressed in the Commission’s report is the latent conflict of interest in the patient advocate office that each VA facility employs to manage and resolve complaints. While patient advocates generally serve as the liaison between patients and clinicians, their ability to fully advocate on behalf of the veteran is hampered by the fact that they are forced to present criticism to those who hold the keys to their career. The “program operates under the philosophy of Service Recovery, whereby complaints are identified, resolved, classified, and utilized to improve overall service to veterans.”³ Capturing useful data by docu-

²Department of Veterans Affairs, Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care, October 30, 2015, pp. 21–25, <http://www.va.gov/opa/publications/va-community-care-report-11-03-2015.pdf>.

³ VHA Patient Advocacy Program, VHA Handbook 1003.4 (2005).

menting complaints in order to facilitate positive changes at VA is productive, but the incentive to downplay patterns of conduct and other pervasive issues exists and limits potential progress. As a solution, PVA has suggested before that the patient advocates should be removed from their current personnel structure and report instead to the MyVA Veterans Experience Office in order to offer more robust, constructive criticism when patterns emerge among veteran complaints.

Recommendation #4: *Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.*

PVA supports this recommendation. The principle of diffusing knowledge and best practices throughout VA is important and should be encouraged. As the report indicates, VA currently has resources, such as the Veterans Engineering Resource Center (VERC), that are underutilized. To truly capitalize on these available benefits, though, VA must thoroughly pursue personnel management reform. A large contributor to stagnant innovation and distribution of best practices is due to persistent, wide-spread vacancies in senior leadership positions. Acting directors or senior managers, as opposed to permanent leaders, have a limited ability to implement long-term changes because of the uncertainty of their tenure. Fixing the issues that pervade the personnel system will go hand-in-hand with success in adopting a continuous improvement methodology.

Health Care Equity

Recommendation #5: *Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.*

PVA supports certain aspects of this recommendation, but we believe that this recommendation perpetuates a false narrative about VA health care prematurely and without a thorough understanding of the scope of the problem. Health care systems across the United States are acknowledging and seeking to address health care equity, inequality and disparities. VA has conducted its own studies and found that disparities do exist. Dealing with these disparities when and where they exist requires affirmative steps to combat the problem. It is essential, however, to thoroughly understand the root causes and true scope of the problem before implementing an effective plan.

VA's unique history of providing care for historically underserved populations, particularly poor or near poor veterans with chronic medical conditions and behavioral health conditions, suggests that patterns within the private sector should not be arbitrarily appropriated to VA without thorough examination. Furthermore, because cost is often not a barrier to care within VA, a significant distinction between VA and private sector care must be made based on the absence of typical market influences affecting private sector outcomes.

Before mandating that VA make "implementation of the VHA Health Equity Action Plan (HEAP) nationwide"⁴ a strategic priority in the face of all the other competing issues, more research and better information is needed to help inform VA's planning and allocation of resources. The 2015 Evidence Brief relied upon by the Commission's report specifically states that the sources of the disparities identified were not examined.⁵ The Evidence Brief concludes that more research, specifically related to the sources or causes of the disparities is needed before an accurate assessment of the issue can be made.⁶ To this end, we support the proposal to plus-up the staff dedicated to examining this issue within VA. It will not only encourage VA to determine how pervasive certain issues are and root out causes of the disparities that exist, but it will also permit VA to apply lessons learned from its own successes, such as its leadership on the issue of health care equity in the LGBT community acknowledged by the Commission in its discussion related to diversity and cultural competence.⁷

Facility and Capital Assets

Recommendation #6: *Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.*

⁴ Report, p. 54.

⁵ Department of Veterans Affairs, Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>, pp. 1, 3, 33.

⁶ Id., p. 28, 31.

⁷ Report, p. 137.

Position: PVA strongly supports this recommendation. VA's capital asset management has been substandard, to say the least, in recent years. We support, in accordance with the recommendations of The Independent Budget, the expansion of ambulatory or urgent care. We also believe that VA must make a concerted effort to right size its infrastructure, in light of the amount of unused and underutilized capacity in the system. However, we are not absolutely convinced that a BRAC-modeled concept is the most effective way for VA to realign its capital footprint. Finally, we fully support the recommendation the report offers to free the VA of the strict fiscal constraints that have hampered its ability to manage its capital leasing program.

Information Technology

Recommendation #7: *Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.*

PVA fully supports this proposed recommendation. We have repeatedly advocated for reform to VA's IT system management and enterprise through The Independent Budget (IB). The IB strongly opposed IT centralization in 2006 (a move forced by then Chairman of the House VA Committee, Steve Buyer). We believe many of the problems identified by the Commission originated with that centralization, and the report essentially affirms our belief. We believe that the Commission's recommendations could be taken even further to fully decentralize IT into VHA once again. This will provide more health care IT innovation, flexibility with the IT budget and better IT outcomes.

However, we recognize that cost for these reforms remains a significant hurdle to advancement. Indeed, VA's Plan to Consolidate Community Care Programs similarly called for significant IT upgrades in order to be successful. The plan was presented to this Committee in late 2015 and was well-received on both sides of the aisle, but several members of Congress balked at the cost of paying for this necessary upgrade. Ultimately, we strongly believe that this is a cost that must be met for VA to have the opportunity to fully modernize its IT infrastructure. This is particularly true in light of the discussion regarding use of commercial off-the-shelf (COTS) IT products.

PVA has no strong position on whether VA should choose a COTS solution for its IT systems or design its own systems. However, it would seem that leveraging COTS would make innovation and modernization more dynamic and possibly more cost efficient.

Supply Chain

Recommendation #8: *Transform the management of supply chain in VHA.*

The Commission accurately outlines the supply and contracting problems within VHA and VA. The corresponding recommendations are good business concepts if VA and VHA have the funding, ability and leadership to implement them. The recommendation to have VA and VHA re-organize all procurement and logistics operations for VHA under the VHA Chief Supply Chain Officer (CSCO) is the correct organizational solution. However, in order to implement the recommendations, there must be multiple changes in other departments throughout VA and VHA. Absent these changes, implementation of these recommendations will cause disruption, confusion and uncertainty at the Central Office level and will be even worse at the field level.

PVA has also identified some additional concerns with the recommendation. The attempt to standardize medical equipment and supplies, as offered in the report, would include prosthetic equipment. The danger is that there is no leadership or expertise in VHA to manage the standardization of prosthetics. There are certainly prosthetic items and supplies that can be standardized, but even those items must be carefully reviewed by an expert clinical team composed of clinicians, contracting, prosthetic and veteran representatives who use the particular items under consideration. Additionally, the report does not contemplate how far down the supply chain standardization of prosthetic equipment should go.

If VA was to pursue the reforms recommended in this section, PVA has a number of implementation level items that could be offered to improve the process and increase the likelihood of a successful transformation.

Governance, Leadership and Workforce

Board of Directors

Recommendation #9: *Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.*

While PVA understands the intent of this recommendation, we do not support it. We agree with the notion that too frequent turnover of VHA leadership has stymied innovative leadership and transformational change. However, replacing politically-appointed leadership with a Board comprised of leaders representing multiple political ideologies will likely lead to even greater gridlock. At the very least, it is simply trading one political entity for another; it does not get rid of the political interference. We can easily envision a scenario where this new appointed Board becomes a reflection of the political leadership of Congress that has demonstrated no ability whatsoever to govern or compromise. While the current leadership of VA is based on nomination by the President and approval by the Senate, this proposal takes political influence too far. One only need to look at the workings of the Commission itself and a number of its politically-motivated members to realize the potential negative consequences politically-driven decisions could have on the delivery of health care for veterans.

Additionally, while the recommendation places emphasis on ensuring veterans are included on the Board, it does not include any real consideration of veterans' service organization representation.

Leadership

Recommendation #10: *Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.*

PVA supports this recommendation. This recommendation cuts at the necessary leadership to effect the cultural changes required to make VHA a more responsive and dynamic organization.

Recommendation #11: *Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.*

PVA supports this recommendation. Succession planning for leadership is a problem that exists across the federal government, not just at the VA. The process by which senior leaders are brought into the VA system, particularly VHA, is cumbersome and complicated. VA too often loses out on some of the best candidates because of the nature of the HR process that fills open leadership positions. The direct-hire authority proposed by the report could provide improved opportunities to bring on critically needed senior staff in the health care system. Additionally, a renewed focus on leadership development and management could ensure that the best candidates are retained in the VHA system.

Recommendation #12: *Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.*

PVA generally supports this recommendation. We believe the vision that the Commission provides for how to change the organizational structure of VHA could prove beneficial to improving management of the system and implementation of policy. We are disappointed that the report does not provide more discussion about the inefficiency of the current VISN structure. Additionally, we remain skeptical about the efficacy of the proposed simplification of the VHA budget. While this sounds reasonable out of context, it does not reflect the complicated nature of budget development and appropriations distribution within VHA.

We do support the notion of more transparent and detailed accounting and disclosure of VHA's expenditures. This recommendation is consistent with recommendations made by the IB during debate and passage of legislation to establish advance appropriations for VA health care.

Recommendation #13: *Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.*

PVA generally supports the creation of a workgroup to establish a new performance management system for VHA leadership. However, we are not certain that it

is appropriate to establish performance metrics that are identical to those used in the private sector. The nature of VA health care delivery is appreciably different from the delivery of health care in the private sector. While there are some aspects that are similar, the VA health care system is not so much like the private sector that it should be evaluated in exactly the same manner. With this in mind, performance standards for employees and management should not be exactly the same either.

Diversity and Cultural Competence

Recommendation #14: *Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.*

PVA generally supports this recommendation; however, we take exception to the implication that VHA somehow lacks the cultural and military competence to provide veterans' health care. VA is the embodiment of veteran cultural competence, and it is, in fact, one of the notable reasons veterans who receive health care from VA prefer it over the private sector. We strongly support the recommendation that cultural and military competence be criteria for allowing community providers to participate in the VA's integrated health networks. In the past, private providers have openly testified before the House Committee on Veterans' Affairs that one of their primary concerns with treating veterans is not understanding veterans and their experiences as patients. This very circumstance is one of the primary reasons that the private sector is not the ultimate solution to VA's access problems.

Workforce

Recommendation #15: *Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.*

Recommendation #16: *Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.*

PVA supports many of the pragmatic ideas found in recommendations 15 and 16 related to VHA workforce issues. A modernized and effective human resources operation is vital to any organization, especially one as large as VA. We believe the federal personnel system is one of the largest hindrances to effective management of the VHA system. Recommendations 15 and 16 deal with two aspects critical to successful reform: the authorities which govern the personnel system and the overall management of human resources (HR) within VHA.

The multiple authorities governing the VHA personnel system are incompatible with a dynamic high-performing health care system. Hiring managers and their employees must attempt to understand the end-to-end hiring process under four separate rules systems. This unnecessarily adds complexity to the hiring system which is difficult for both the potential employee and the human resources staff to navigate. The unnaturally slow hiring process also produces lost talent. Quality employees do not often have the luxury to wait around for a VA employment application to be processed. Similarly, when an employee announces his or her forthcoming retirement or departure from VA, HR is unable to begin the recruiting or hiring process for that position until it is actually vacated. It not only causes an unnecessary vacancy - exacerbated by the lengthy hiring time - but it also prevents a warm handoff between employees and any chance for training or shadowing.

PVA also believes that VA has suffered from its inability to be competitive with its private sector health care counterparts who do not face the same restrictions on pay and benefits for critical staff. We support the recommendations to align pay and benefits to make the VA more competitive for important staff with the private sector.

The broad recommendation to consolidate all personnel authorities into one alternative personnel system will bring wide benefits, but it must also include increased flexibility in the actual hiring process. It must also establish clear standards for disciplining or removing poor performing employees without diminishing current due process protections afforded by law.

In short, the VHA workforce arena is ripe for numerous practical changes that would provide realistic opportunities to reconcile personnel reform and preservation of the due process protections currently afforded to VHA employees.

Eligibility

Recommendation #17: *Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.*

PVA supports this recommendation. This recommendation mirrors legislation introduced earlier this year-S. 1567 and H.R. 4683, the "Fairness for Veterans Act"-which PVA publicly supported. There is overwhelming evidence that the effects of war can cause psychological harm, drastically changing the personality and behavior of servicemembers. Sometimes those effects manifest and adversely affect the terms of the veteran's discharge. It is a poor irony and ultimately unjust to withhold care for an injury incurred during service solely because that injury provoked or caused the actions which led to their discharge classification. While most commanders are dedicated and caring leaders, many do not have the intimate knowledge of a servicemember's behavior prior to the trauma they experienced during military service. Other leaders may even find it "expedient" to rapidly discharge an individual to rid themselves of a problem in the unit. Too often these discharges are determined without regard to the cause of the altered behavior. Having an effective mechanism to review the discharge in a deliberate manner can ensure that veterans deserving of care for injuries incurred as a result of their service are not denied.

Recommendation #18: *Establish an expert body to develop recommendations for VA care eligibility and benefit design.*

PVA is very cautious of this recommendation. The Commission generally supports with evidence its belief that the issue of eligibility needs to be reexamined or updated in order to better align capacity and demand. But it does not support or even present a rationale for why this undertaking should be conducted by an entity outside VA or Congress. The recommendation to outsource this task treads into the territory of eligibility with a different, and potentially harmful, perspective - that of business efficiency.

The benefits currently afforded to, for example, Priority Group 4 veterans reflects years of hard work and advocacy that forced our country's representatives to make tough business decisions within the context of long-accepted philosophical principles. What this country owes its veterans and what it can afford to pay cannot always be reconciled. It does not absolve this nation's responsibilities to its veterans. In such circumstances VA and Congress should act from the perspective that they must fight not just to better manage resources but to also find the necessary appropriations to cover the obligation. "Restructuring the debt" and trimming veterans from the rolls based on a cold and calculated business-driven decision is not an option. The budget must not be balanced on the backs of veterans.

Conclusion

Mr. Chairman, we would like to thank you once again for the opportunity to testify on this important issue. This concludes our statement for the record. We would be happy to answer any questions the Committee may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, thank you for the opportunity to offer our thoughts on the Commission on Care's final report.

The VFW thanks the Commission on Care for their hard work and extensive deliberations on how to improve the health care and services a grateful Nation provides its veterans. In particular, we thank Chairperson Nancy Schlichting for her work to build consensus among the commissioners and for her willingness to work with the major Veterans Service Organizations (VSOs) in order to gain an understanding of what veterans like and want to see improved in their health care system.

While the VFW does not support every recommendation made by the Commission, we certainly believe the Commission accomplished its mission to propose bold transformation that can improve access to high quality care for our Nation's veterans. The VFW urges Congress and VA to act on the recommendations we support and consider alternatives to the ones we oppose.

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Similar to the Independent Budget's "Framework for Veterans Health Care Reform," the Commission recommends developing high performing, integrated and community based health care networks that leverage the capabilities of private and public health care systems to meet the health care needs of veterans in each community. The VFW is glad to see the Commission also agrees that VA must remain the coordinator of care for veterans and must develop systems and processes to help veterans make informed health care decisions. Doing so is vital to ensuring veterans receive high quality and coordinated care, rather than fragmented care which the Commission agrees results in lower quality and threatens patient safety.

That is why the VFW opposes the Commission's proposal to give veterans a list of primary care providers and then find one willing to see them. The VFW does not believe it is necessary to trade quality care coordination for choice. Veterans in need of a primary care provider must be offered the opportunity to discuss their preferences and clinical needs with a VA health care professional to determine which provider (including private sector, VA and other public health care providers) best fits their preferences and clinical needs. This would ensure veterans make informed choices and receive care tailored them.

The VFW is also concerned that the Commission's recommendation on how veterans would navigate its proposed community delivered service (CDS) within the Veterans Health Administration (VHA) care system ignores the Commission's key findings regarding care coordination. Instead of fully leveraging the nurse navigators "to help veterans coordinate their care in VA and in the community," as the Commission describes as a possible supplement to its CDS recommendation, it calls for private sector primary care providers to coordinate the care veterans receive and leaves veterans to fend for themselves when scheduling appointments with community specialty care providers.

While we agree that a veteran's primary care provider must have visibility of all the care a veteran receives at VA and in the community, we strongly believe VA, not the primary care provider, must serve as veteran's medical home. This includes helping veterans schedule appointments with specialty providers when they receive a referral from their primary care provider, which would ensure veterans receive care that fits their preferences and clinical needs. This also includes consolidating a veteran's medical history into one electronic health care record that is accessible by the veteran's VA and community health care providers.

In an effort to alleviate demand on its primary care providers, VA is moving towards direct scheduling for certain specialty care, such as optometry and audiology. The VFW agrees with VA that certain types of care may not require a primary care consult and believes VA must have the ability to waive primary care referral requirements for such specialties. Such waivers must also apply to veterans who receive care through community care networks, which further exemplifies the need for VA to serve as the medical home for enrolled veterans.

Counter to the Commission's recommendation, the VFW does not believe that the majority of eligible care would shift from VA facilities to the community care networks. VFW surveys and direct feedback from veterans indicate that veterans would like to receive more of their care from VA health care professionals who know how to care for their service-connected conditions. In the VFW's "Our Care" report from September 2015, we found that 53 percent of veterans prefer to receive their care from VA providers, which is higher than VA's reported reliance rate of 34 percent. VFW surveys of veterans who are eligible for the Choice Program under the 40-mile rule, which affords them the option to receive private sector care without a referral from a VA provider, also indicate that the majority of veterans continue to prefer VA providers despite having unfettered choice.

However, the VFW is very concerned that open networks could lead to veterans receiving care from providers that are available instead of the ones they prefer. The VFW has heard from veterans who use the Choice Program that they would prefer to go to VA, but their local VA facilities do not provide the services they need, or they would have to wait too long for an appointment.

The VFW fears that VA and Congress would interpret such veterans' use of private sector care as their preference for private sector care, when in reality they would have preferred to receive VA care, but private sector care was their only option. Doing so could lead to more resources being directed to community care networks and further depleting resources VA is given to expand access to the care veterans prefer. That is why the VFW believes continuous evaluation and adjustments

to community care networks, as recommended by the Commission, must be based on veterans' preference, not simply utilization of networks.

Regardless if care is delivered through community providers or VA medical facilities, VA must remain the guarantor of care to ensure such care is high quality, veteran-centric and accessible. That is why the VFW strongly supports the Commission's recommendation that VA require community care network providers to report quality, service and access metrics. The VFW also believes veterans who receive care through community care networks must be afforded the same patient rights and protections they receive at VA medical facilities.

The VFW also supports a phased implementation of integrated networks with ongoing management and evaluation, national strategy and local flexibility to ensure veterans' needs are met. However, the VFW opposes the Commission's recommendation of establishing a board of directors, as discussed in our views of recommendation number nine, and believe management and implementation of integrated networks must be overseen by a multidisciplinary team of VA subject matter experts with direct and consistent guidance from local VA health care professionals and VSOs, similar to the approach VA used to develop its plan to consolidate community care programs and authorities.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

The VFW supports the recommendation to develop training programs for medical support assistants (MSA) to ensure VA health care providers devote more time to treating veterans rather than administrative tasks.

While training is important, VA must also address the high turnover in MSA and entry level positions at the local level. VA has developed an expedited hiring process for MSAs as part of the MyVA transformation. The VFW fully supports this initiative, but believes VA must have statutory authority similar to the VA Canteen Service, which is exempt from title 5 hiring requirements and can directly hire entry level employees to fill high turnover positions.

The VFW does not take a position on the recommendation to grant full practice authority to advance practice registered nurses. The VFW defers to VA in determining the most efficient and effective scope of practice of its providers. However, we will hold VA accountable for providing timely access to high quality health care, regardless if such care is provided by an advance practice registered nurse or a physician.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

VFW members have experienced firsthand the pitfalls of VA's clinical appeals process. The VFW agrees with the Commission that a well implemented clinical appeals process is necessary to improve patient satisfaction, ensure veterans obtain medically necessary care, and mitigate disagreements between veterans and their health care providers. Currently, veterans who disagree with clinical decisions by their health care provider can appeal to the medical center's chief medical officer, who is reluctant to overturn a decision made by VA health care providers. A veteran is then able to appeal to the Veterans Integrated Service Network (VISN) director, who rarely overturns a decision made by a medical center chief medical officer. The VISN level decision is final, unless a veteran appeals to the Board of Veterans Appeals, which is not a viable option for veterans who require time sensitive medical treatments.

Due to the lack of a system wide clinical appeals process with national oversight, veterans have experienced vast differences when appealing clinical decisions between multiple VISNs. That is why the VFW strongly agrees with the commission's recommendation to convene an interdisciplinary panel to revise VA's clinical appeals process. Such a panel must ensure veterans have the ability to provide justification or evidence to support their appeals, which many VISNs do not permit. Veterans must also have the ability to appeal clinical decisions above the VISN level.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

The VFW agrees that improving employee experience is a vital aspect of reforming the VA health care system. The majority of VA employees take pride in their

jobs and continuously identify ways to improve efficiency and productivity. However, such employees have not been given the tools or the processes to identify problems and make changes. That is why the VFW supports efforts to identify and disseminate best practices and recognize innovative employees who improve the care veterans receive.

Health Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The VFW supports this recommendation and agrees that health disparities based on social and economic differences have no place in the VA health care system. The VFW has heard directly from women veterans that VA employees have confused them for caregivers and spouses, or have challenged their veteran status because of their gender. Veterans of all races, backgrounds, and genders have sacrificed in defense of this Nation and must be treated with the respect and dignity they have earned and deserve.

The VFW strongly supports building cultural and military competence among all community care network providers and employees. It is important that veterans receive care from providers who understand their health care needs and are familiar with the health conditions associated with their military service. This includes providers in VA medical facilities and private sector providers who participate in community care networks. By providing cultural competence training, VA would improve health care outcomes and ensure veterans receive care that is tailored to their unique needs.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital asset needs.

The VFW agrees with most of the recommendations provided regarding capital infrastructure.

We agree that waiving congressional rules requiring budgetary offsets for a period of time and expanding the enhanced-use lease authority will allow VA to enter into needed leases, without accounting for the cost of the entire lease in the first year. However, suspending this offset requirement for a few years will leave VA in the same position it finds itself in today if Congress does not find a long term solution to VA's leasing authority. VA also needs broader authority to enter into enhanced-use leases agreements. Public Law 112-154 reduced VA's authority to allow for only adaptive housing. Returning it to its prior authority will allow VA to lease more of its unused or underutilized property, while still contributing to the mission of VA.

The VFW also agrees that reevaluating the total cost of minor construction projects is needed. Currently, VA will submit multiple minor construction projects that appear to be related for a single facility. This is evidence that either the \$10 million cap on minor construction projects needs to be increased or VA needs the authority to bundle multiple minor contracts for the ease of planning and appropriating several minor projects at one time without violating the \$10 million cap. Regardless of whether the cap amounts are adjusted, underfunding will continue to place much needed construction projects in competition with each other. Congress must fund VA construction accounts to a level where projects to expand access are not in competition for resources for new facilities or eliminating safety risks in facilities VA must maintain.

The Commission recommends that a board analyze and make recommendations regarding VA's infrastructure needs and the CDS networks. The VFW believes that most of the functions of this proposed commission are already being carried out by either the Strategic Capital Infrastructure Plan (SCIP) or the Federal Real Property Council (FRPC). The VFW believes that the current roles of SCIP and the FRPC would need to be expanded to include the evaluation of community care on the overall capital planning process. SCIP analysis should be expanded to include the feasibility for public-private partnerships and sharing agreements with other public and community providers. This would fulfil the idea of better leveraging community resources to expand VA's capacity and capabilities.

The VFW does not agree with the Commission on Care's BRAC realignment commission. The SCIP process already addresses the issue of under/unutilized property, and it is Congress that has failed to act to remove these properties. The reason they have failed to act is the same reason they would fail to act under a BRAC-style recommendation—local pressure from the veterans' community would cause them to

vote “no.” The solution is to develop better communication with the local veterans’ community and present the replacement plan that will occur when their VA hospital is closed. Veterans’ fear of losing VA care drives Congress’ inaction, and no commission or board will fix that without improved communications.

Information Technology

Recommendation #7: Modernize VA’s IT systems and infrastructure to improve veterans’ health and well-being and provide the foundation needed to transform VHA’s clinical and business processes.

The VFW agrees that VHA must have a chief information officer (CIO) to focus on the strategic health care information technology (IT) needs of the VA health care system. VA Assistant Secretary for Information and Technology LaVerne Council has discussed the need for a senior level employee to oversee VHA IT projects. The VFW agrees that the VHA CIO must work closely with VHA clinical and operations staff to ensure IT systems meet the needs of their users, but continue to report to the Assistant Secretary for IT to ensure interoperability with Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) systems.

The VFW agrees that the lack of advance appropriations for VA’s IT accounts has hindered VA’s ability to properly fund IT projects, specifically ones associated with VHA which is funded under advance appropriations. That is why the VFW has continuously called for Congress to provide advance appropriations for all of VA’s budget accounts. We thank this Committee and the Senate Committee on Veterans’ Affairs for enacting legislation to authorize advance appropriations for VA’s medical services and mandatory accounts to ensure veterans can continue to receive care and benefits during a government shutdown, but it is vital that VA’s remaining accounts, including IT, community care, research, NCA, VBA, Inspector General and VA’s four construction accounts receive advance appropriations to ensure VA can fulfill its mission to veterans.

The VFW does not have a position on whether VA should purchase a commercial off-the-shelf (COTS) electronic health care system. However, the VFW agrees that VA should turn to COTS products when such products are financially beneficial and lead to improved services for veterans, but VA must have the authority to develop homegrown products when necessary.

Supply Chain

Recommendation #8: Transform the management of supply chain in VHA.

The VFW supports this recommendation to reorganize and standardize VA’s supply chain to leverage economies of scale. This recommendation is similar to one of Secretary Robert McDonald’s MyVA priority goals aimed at building an enterprise-wide integrated medical-surgical supply chain that leverages VA’s scale to drive an increase in responsiveness and a reduction in operating costs, which the VFW fully supports.

This transformation must rely on local level feedback and buy-in to succeed. While each medical facility cannot continue to dictate where their medical supplies are purchased, they must be given the opportunity to request specific supplies or products if needed in order to provide the best quality care. This is similar to non-formulary requests for prescriptions that are not on the VA’s formulary. The transformation must also consider whether specific products are preferred or clinically needed by veterans, such as prosthetics equipment that may cost more, but lead to a better quality of life for veterans.

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The VFW opposes this recommendation. The VFW believes VA needs leadership, not management by Committee. Similar to the Commission on Care, the governance board would include political appointees, the majority of whom would be civilian health care executives and veterans who do not use the VA health care system. How, when and where veterans receive their health care cannot be determined by appointees who do not have a vested interest in improving the care and services veterans receive.

Additionally, the VFW believes that a governance board would result in more bureaucracy. VHA’s budget requests would still need to be approved by the Office of Management and Budget and appropriated by Congress. This recommendation also fails to resolve the misalignment between capacity to provide care and the demand

on its programs that is highlighted in the Commission's report. The VFW recommends reforming the congressional appropriations process to ensure VA receives the resources it needs to meet veterans' health care needs, instead of creating more bureaucracy and further limiting how much care VA is able to provide.

A number of reform ideas have been discussed to address this issue. One proposal is to make VA's health care accounts mandatory spending. Doing so would exempt VA health care accounts from discretionary budget caps which have limited VA's ability to expand access and implement needed reforms. Another proposal is to provide VA a true two-year budget by authorizing VA to transfer advance appropriations to its current year budget to cover budget shortfalls. However, such ideas have not been given proper consideration by Congress. The VFW believes it is time to consider innovative reforms to the VA health care appropriations process.

This Committee, the Senate Committee on Veterans' Affairs, the Secretary of Veterans Affairs and the President must continue to provide oversight and management of the VA health care system with or without a governance board. Thus, a governance board would mean that VHA leadership would have additional management and reporting requirements which would only serve to further stymie the needed transformation process.

Leadership

Recommendation #10: Require leadership at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

The VFW supports this recommendation. As discussed above, employee experience is vital to restoring veterans' trust and confidence in their health care system. Secretary McDonald is in the process of addressing this recommendation by transforming VA from a rules based culture to a principles based culture that empowers VA employees to do what is right, instead of fearing reprisal for not following every rule. Several veterans have reported improvements in the culture at VA medical facilities, but more work is still needed.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

The VFW supports this recommendation. We agree with the importance of succession planning and the need for robust structured programs to recruit, retain, develop and promote responsible and high performing leaders. Specifically, the VFW strongly supports the recommendation to adopt and implement a comprehensive system for leadership development and management. VA employees must be prepared and willing to fill vacancies in leadership positions to ensure VA is not required to rely on temporary leadership to run its medical facilities.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

The VFW generally supports this recommendation. We agree that the VA central office and VISN office staff have grown too rapidly and that fragmented authorities, lack of role clarity and overlapping responsibilities impacts VA's ability to deliver high quality and efficient health care. Specifically, the VFW agrees that VHA must consolidate program offices to create a flat organizational structure to streamline VHA's current cumbersome and duplicative organizational structure.

The VFW understands the Commission's recommendation that Congress should reduce the number of VA appropriations accounts. While it is essential for Congress to use its power of the purse to influence VA programs, Congress must do so effectively and not impede VA from fulfilling its mission. For example, the Military Construction and VA Appropriations Act recently passed by the House and being considered by the Senate limits VA's VistaA Evolution project to \$168 million, but requires VA to meet certain requirements before the funds become available. While the VFW understands the need for such reporting requirements, we believe VA must have the flexibility to use such funds immediately. Withholding such funds only serves to further delay VA's plans to modernize its electronic health care record.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management sys-

tem for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

The VFW supports this recommendation. It is important to develop a performance management system that effectively measures outcomes and holds VA leaders accountable for improvements.

However, the VFW does not believe such performance measures need to be identical to those used in the private sector. VA performance measures must adopt best practices from the private sector, but they must also acknowledge VA's unique mission and the fundamental differences between private and public health care systems.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veterans' health outcomes.

The VFW strongly supports this recommendation. As discussed above, cultural and military competence training of providers would ensure veterans receive care that is tailored to their unique needs.

It is particularly important to build cultural competency among community care providers who do not have experience caring for veterans or may not be aware of best practices when caring for veterans with service-connected wounds and illnesses. A study by the RAND Corporation found that only 13 percent of private sector mental health care providers are ready and able to provide culturally competent and evidence based mental health care to veterans. The VFW believes VA must leverage the capacity of the private sector to provide mental health care to veterans, but it must also ensure veterans who use community care receive high quality and veteran-centric care by providing military competency training and sharing best practices with community care providers and ensuring such practices are adopted.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

The VFW supports this recommendation. VA must be able to recruit, train, retain and discipline a high performing workforce. The VFW agrees that civil service laws and regulations that govern how government employees are hired, how much they are paid, and how they are disciplined were not designed to support a high performing health care system. VA must have a personnel system that eliminates barriers to hiring and retaining high quality employees.

We agree with the Commission that Congress must afford VA employees appropriate due process to appeal disciplinary actions. The VFW has also supported a number of accountability measures considered by this Committee, including H.R. 5620, the VA Accountability First and Appeals Modernization Act of 2016, which would expand the Secretary's ability to remove or demote employees for poor performance or misconduct. Overall, the process that is taken to remove or demote VA employees who commit malfeasance must ensure such employees are no longer allowed to collect a paycheck or harm veterans, but protect good employees and whistleblowers from being wrongfully terminated or retaliated against.

The VFW also agrees with the need to improve VA's student loans reimbursement programs. However, VA is already authorized to reimburse health care professionals up to \$120,000 over five years of student debt, which is similar to the National Health Service Corps' loan repayment plan program. While the VFW would support increasing the amount VA health care professionals may receive, it would not make VA more competitive when hiring or retaining high quality employees, because local facilities are not given enough funds to fully utilize this program. For example, the VFW heard from a VA nurse that her medical center is given \$80,000 per year for the education debt reduction program. These means the facility could reimburse three providers the maximum allowed amount of \$25,000 or divide the \$80,000 amongst its dozens of providers and render the retention incentive ineffective. To properly utilize this incentive, Congress and VA must properly fund this program.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

The VFW supports this recommendation. We often hear from VA medical facilities that they struggle to hire needed staff because of the cumbersome human resources (HR) process. Specifically, the outdated and ineffective rules and regulations that govern when and how VA can recruit possible candidates puts VA at a disadvantage when competing with the private sector to recruit high quality health care professionals.

Secretary McDonald has made some progress in addressing this issue by deploying rapid process improvement workgroups which identify and resolve regulatory barriers that adversely impact the hiring process and improve an applicant's experience when applying for VA jobs. However, the VFW agrees with the Commission that VA HR systems and processes must be prioritized and improved. It is unacceptable for VA HR professionals to be required to operate 30 disparate IT systems. When HR is unable to do its job efficiently, VA medical facilities are not able to fill vacancies quickly, which leads to access problems that negatively impact veterans. It is also deplorable that VA's cumbersome HR rules and processes impede its ability to remove or demote wrongdoers.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an Other-Than-Honorable discharge who have substantial honorable service.

The VFW fully supports the recommendation to amend VA's current health care eligibility regulation and provide VA health care and benefits to veterans with other than honorable (OTH) discharges, if their overall service is deemed honorable. Under current law, a veteran who meets other eligibility criteria and has a discharge that is other than dishonorable is eligible for VA health care. However, VA's process for determining which veterans are considered to have an other than dishonorable discharge is flawed, and generally results in veterans who have anything less than an honorable discharge being denied benefits.

This is a particular concern for veterans who served honorably in combat, but were administratively discharged upon returning home due to relatively small infractions, like missing formations or being charged with alcohol-related incidences. VA regulations do not consider discharges for minor offenses as dishonorable, if such veteran's service was otherwise honest, faithful and meritorious.

Unfortunately, VA's process for determining eligibility is not consistent and often fails to properly account for a veteran's entire service. In their recent report, "Underserved: How the VA Wrongfully Excludes Veterans with Bad Paper," Swords to Plowshares, the National Veterans Legal Service Program and the Veterans Legal Clinic at the Legal Service Center of Harvard Law School found that instead of granting OTH veterans the health care and benefits they have earned, VA has lumped them in with bad conduct and dishonorable discharges, which are reserved for servicemembers convicted of wrongdoing at a court martial—thus resulting in 90 percent of OTH veterans being denied the benefits and services they have earned.

Without access to VA health care, those suffering from service-related mental health injuries are left on their own to deal with their mental health symptoms, making recovery nearly impossible. The VFW supports amending VA's regulation to ensure veterans with OTH discharges who committed minor infractions but otherwise completed honorable service, receive full eligibility for health care and benefits. Additionally, VA must also ensure veterans who present to a VA medical facility with a medical condition that requires urgent or emergent medical attention, such as a veterans who shows signs of suicidal ideation, are not required to undergo a cumbersome character of discharge review before receiving lifesaving care. Veterans who are later determined to be ineligible for VA health care must be transitioned to other health care options, but veterans cannot be denied lifesaving care simply because VA rules require a flawed and time consuming character of discharge review process.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefits design.

In every past evaluation and change to the eligibility criteria for health care, access to care was increased to unserved populations of veterans, or eligibility was realigned to conform with an updated delivery model. With those two facts in mind, and understanding that the development of an integrated health care system will

deliver care under a different model, the VFW supports the idea of studying access barriers based on current eligibility criteria while ensuring service-connected, home-bound and catastrophically disabled veterans do not incur barriers or delays in services or care. Additionally, the VFW would oppose any proposal to increase the health care cost shares for veterans.

VIETNAM VETERANS OF AMERICA (VVA)

Chairman Miller, Ranking Member Takano, and distinguished members of this august Committee, Vietnam Veterans of America presents for the record, and for your consideration, our observations on the final report of the Commission on Care.

Before we offer VVA's comments, we do want to acknowledge the yeoman efforts, accomplished on a very tight timeline, by the commissioners and the very knowledgeable and gifted commission staff. In particular, we want to applaud the strong and steady leadership of commission chair Nancy Schlichting, who piloted a ship with a diverse crew with very different ideas through very rocky waters. She deserves our praise, and your thanks.

During public meetings of the commission, a number of folks, including the Chairman of this Committee, acknowledged that without a buy-in from the veteran's service organizations, the commission's recommendations, their vision, would not go very far. Although there are several very well-thought-out and logical recommendations that ought to be adopted via legislation from Congress or regulation from the Department of Veterans Affairs, the "big picture" as conceptualized by the commission is in many respects problematical, and cannot garner VVA's assent.

Certainly, however, VVA does not quibble with the stated mission of the commission: to enhance and improve a health care delivery system that will "provide eligible veterans prompt access to quality health care."

Let us begin with some facts:

- The Commission on Care was borne of the so-called Choice Act, enacted into black-letter law after legislators and the media finally recognized a situation that had existed for some two decades. It was a "scandal" that galvanized Congress to act, however belatedly. In fact, the media often put the adjective "beleaguered" before "VA" in their reportage after the scandal broke. That neither Congress nor the Administration nor the media had taken heed about a long-standing situation before did not even make the back-story.
- The Veterans Health Administration is an integrated managed care network, the largest in the nation. Long before the legislation that created the Choice Act, a provision of which established the Commission on Care, the VHA availed veterans of care by community providers, when necessary or appropriate. More than one out of every ten VA health care dollars was expended outside of VA Medical Centers and community-based outpatient clinics, or CBOCs.
- VA Medical Centers, for the most part, provide "one-stop shopping" for primary and specialty care, something that is not afforded at most private-sector hospitals and health care facilities. In addition, the VHA, under the gritty leadership of the current Under Secretary for Health Dr. David Shulkin, is making significant strides in transforming the VA health care system and embracing greater community care.
- The quality of care in VHA facilities is good to excellent and is in many areas superior to care from private hospitals or medical centers. This the commission has acknowledged. The issue is, as it has been, one of access into VA health care facilities, where there are too few clinicians to meet the needs of the veterans the VA is charged with serving. Yet the shortage of health care professionals is hardly limited to the VA; this is a national problem, one that is particularly acute in rural and remote areas as well as in inner cities.

Now, it should be noted at the outset that the commission's recommendations for transformative change in health care delivery are not intended as an immediate palliative; rather, the charge of the commission was to envision what the VA health care delivery system should look like in 20 years, and to provide a blueprint on how to get there.

To the commission's credit, commissioners rejected the goal of some to privatize VA health care. They nixed the idea of unfettered "choice," of giving eligible veterans the option of going to any private-sector health care providers of their choosing, with the VA footing the bills, which would have transformed the VA, in effect, into a source of income. They would scrap the time (30 days) and distance (40 miles)

criteria for access to community care, one of the provisions of VACAA, the Veterans Access, Choice, and Accountability Act.

Several of the commission's recommendations ought to be seriously considered and adopted, via either legislation or executive action. These, which can be done under the current construct of the VHA, include:

- Convening "an interdisciplinary panel to assist in developing a revised clinical-appeals process" (Recommendation #3).
- Consolidating idea and innovation portals, and best practices and continuous improvement efforts, in the currently underutilized Veterans Engineering Resource Center. The commission imagines the VERC as having considerable input in properly aligning "systemwide activities [that] require substantial change"- human resource management, contracting, purchasing, information technology (Recommendation #4).
- Making health care equity "a strategic priority," increasing "the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures" (Recommendation #5).
- Because the VHA "not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings . . . it is critical that an objective process be established to streamline and modernize VHA facilities . . ." The commission also offers that the "facility and capital asset realignment process" be modeled after the wildly unpopular but necessary DoD Base Realignment and Closure Commission (BRAC) process "as soon as practicable." With Congress not overly enthusiastic about the BRAC process for eliminating outmoded or unneeded DoD facilities here in CONUS, to think that legislators will embrace this idea of shuttering VA facilities is pie-in-the-sky (Recommendation #6).
- " . . . VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health" (Recommendation #7).
- Because VHA's supply chain management "is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management," the VA should establish the position of VHA chief supply chain officer, to be compensated "relative to market factors," the first step in achieving "a vertically integrated business unit extending from the front line to central office" (Recommendation #8).

Perhaps the key recommendation of the commission that we can embrace is the need to achieve strong, sustained - and sustainable - leadership on all levels of the VHA. Congress must therefore authorize "new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts." The VHA also should establish "two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs."

What the commission advocates here, and what was a key discussion point during its public meetings, is the need to attract, and to train, the best and the brightest, who would serve for a set term or the long term, and who would be recompensed according to the market in a particular catchment area. To achieve this, Congress must empower the VHA to offer competitive salaries and benefits to attract the most qualified candidates, both from within and from out of the VHA hierarchy (Recommendation #11).

The commission notes the need for "developing the cultural and military competence of [VHA] leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans." The commission is on target in asserting that "cultural and military competency" must be among the criteria for "credentialing" external clinicians to treat veterans (Recommendation #14).

Finally, here is a relatively radical recommendation that warrants congressional scrutiny and consideration: "Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service." The commission recognizes, rightfully, that some former servicemembers in

fact “have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service,” thus rendering them ineligible for VA health care and other benefits. “This situation leaves a group of former servicemembers who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides” - care that they vitally need.

The commission proposes, “VA revise its regulations to provide tentative eligibility to receive health care to former servicemembers with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.” This may not be simply a matter of the VA revising regulations - Congress will need to enact legislation to enable the VA to treat these veterans - but it is an idea worthy of merit.

THE FUNDAMENTAL PROBLEM, however, with the commission’s conceptualization for the future of VA health care commences in the language of its initial recommendation. This calls for “. . . community-based health care networks” that will “integrate health care within communities.” This would essentially fold VA-provided health care into a wider community-oriented network of providers rather than integrating local or regional providers into a VA network. It is this overall structure envisioned by the commission of a “new” VHA that is the problem.

Perhaps more basic to the relationship between clinician and patient is the assumption that most veterans want to choose their primary and specialty health care providers. This precept, the second basic issue we have with the commission’s blueprint, is fundamentally flawed. The commissioners tripped up in paying fealty at the altar of Choice, in conceptualizing an entirely new governance structure, in sublimating VA health care facilities into an expansive community context dubbed the “VHA Care System.” Yes, by all means VA clinicians should continue to refer veterans to outside providers when and where appropriate to improve access as well as to provide care that VA clinicians are unable to deliver. However, no, the VA should not cede, as the commission recommends, the role of primary care clinician to non-VA personnel; this would be a critical misstep, undermining the integrity and managed care the VA offers.

If a veteran needs to see a specialist, s/he often has little ability to divine on his or her own whom to go to and must rely on the recommendation of their primary care provider. In the brave new world envisioned by the commission, the veteran can “choose” to see the “credentialed” specialist of his/her choice. Does anybody really think that this will enable a veteran to get same-day service from a busy clinician? Alternatively, provide better care than s/he can receive at a VAMC or CBOC? On the other hand, save the system money?

In addition, consider the potential for this: If a patient who is covered by private health insurance chooses to be treated by a physician not in the network assembled by her health insurer, she has to pay that doctor out of pocket and fill out a claim form to receive some reimbursement from her insurer. Yet what if that veteran wants to go to a clinician whom the VA has not credentialed? Will he have to shell out his own money, even if he has a disability rated at, say, and 70 percent? Will that veteran complain to his Member of Congress, who will then demand from the local VHA Care System why Dr. X has not been “credentialed”? It is not difficult to foresee a bureaucratic headache of major proportions.

“Foundational among the changes” the commission seeks is “forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.” This is the third fundamental misconception of the commission. The governing board that the commission envisions as necessary to achieving a “bold transformation” ignores reality. Their “Board of Directors” would be a paper tiger that, without the power of the purse, can only recommend, not appoint or institute, thus making it a board of advisors.

In addition, veteran service organizations and veteran leaders in effect already function as an informal board of advisors on the national and local levels. The VA would have far fewer perceptual problems if its leaders and senior managers acknowledged this and worked in concert with VSOs as a matter of course, seeking and embracing our ideas and input at the beginning of a process, not pro forma near its conclusion.

The commission also calls for the creation of “a simple-to-administer personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.” Such a system would render VA hiring as separate and unequal to how hiring is done in the rest of the federal

government. (There can be little argument that "VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century.") Hence, the recommendation that "Congress create a new alternative personnel system . . . in collaboration with union partners, employees, and managers . . . that applies to all VHA employees and falls under Title 38 authority . . . and improves flexibility to respond to market conditions relating to compensation, benefits, and recruitment."

On one hand, this makes eminent good sense: to obtain and retain top professionals in both medical treatment and hospital administration, the VA health care system needs to be competitive with the incentives in the private sector. Moreover, certainly, VHA's ability to hire qualified staff cannot continue to be hamstrung by bureaucratic constraints and ineptitude. While many clinicians choose to work at the VA because of job security and protected pensions, others also feel a calling to use their skills to care for the men and women who have served the nation in uniform, many of whom have special needs derived from their wartime experiences.

On the other hand, however, Congress quite likely will be skeptical at best about setting precedent by creating an alternative personnel system. Convincing you in Congress to in effect turn the VHA into a quasi-governmental entity while continuing to fund its operations will be the ultimate hard sell. It was the wait-time access issue, a long-time reality in many VA medical centers that raised the ire of Congress, not the quality of health care delivered by VAMC personnel. Integrating additional health care providers into the VA system, where appropriate and when needed, is part of the rejuvenation of the VHA under the current Undersecretary. This makes sense.

The conceptualization of the commission to create a new entity, one in which VA and private sector clinicians, many with similar skill sets, in essence "compete" to treat veterans will not materially improve health care for those veterans who obtain their care at a VA facility. It is likely to dramatically increase the costs of providing care; and it is likely to lead to the underutilization of certain VA medical centers and community-based outpatient clinics and the subsequent shuttering of several of them, with the consequent turmoil in staff morale and, eventually, the loss of tens of thousands of jobs. Still, the VA must resolve a situation that continues to plague it: "Hiring timelines [for medical professionals] can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months." (See Recommendation #16.)

There is yet one more recommendation that we find problematical.

Prefacing this, the commission acknowledges that the capacity of the VA to provide care "is constrained by appropriated funding." In its recommendation that Congress or the President charge some entity with examining the "need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria," the commission opens the door to initiating pilot projects "for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance."

The 1996 eligibility reform act created eight "priority" groups of veterans eligible for VA health care. Priority 7 and Priority 8 veterans, who are not afflicted with service-connected conditions, must agree to a co-pay for the health care and prescription drugs they receive from the VA. They account for some 40 percent of third-party collections by the VA. In addition, the Vet Centers, as a matter of course, do treat the family members of veterans, a necessity to successfully treat many of the mental health maladies suffered by the veterans they love.

To open a beleaguered health care system to non-vets seems counter-productive. Moreover, it also would dilute the very essence of what should be a veteran-centric system. Because there is a certain specialness inherent in receiving care in a place where your service is acknowledged, where an array of conditions - traumatic amputations, spinal cord injuries, mental health afflictions - are understood, where you are among your peers. On this, a monetary value cannot be placed (Recommendation #18).

The commission acknowledges the *raison d'être* for its own creation by the same act of Congress that initiated the so-called Choice Program: the issue of access. Yet it also acknowledges, "Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals."

The commission notes the key question with which Congress must grapple: Does the VA health care delivery system, despite the wait-time scandal, require "fundamental, dramatic change - change that requires new direction, new investment, and profound reengineering"? This is a question VVA and other VSOs, MSOs, and veterans across the country need to consider: Can the VA, given the impetus generated

by the issue of access, fix itself, or does it require a radical reformation, one that can conceivably result in its demise?

We believe that the VA, specifically the Veterans Health Administration, can fix itself and in fact is fixing itself, in great measure because of the impetus generated by passage of the VACAA. We would hope that you in Congress will monitor what VA leadership is accomplishing; and that members of the media who cover veterans issues would focus less on dramatically highlighting the problems and more on what is being done to ameliorate them. When the VA messes up, by all means report it and let Congress call VA leadership on the carpet. However, report, and so acknowledge, some of the good things that the VA has been doing, e.g., making what is now a cure for hepatitis C available to all veterans enrolled in the VA health care system. Thousands of lives are being saved, and this, too, ought to be reported.

Vietnam Veterans of America appreciates having the opportunity to submit, for the record, our position and our conclusions vis a vis the recommendations of the Commission on Care. In addition, we thank you and members of the Senate Veterans Affairs Committee for all that they have done, and are doing, for veterans and our families.

HEALTHCARE PROFESSIONALS FEDERAL UNION

POLICY BRIEF RE COMMISSION ON CARE FINAL REPORT: MAJOR RECOMMENDATION IGNORES DATA, RISKS VETERANS' HEALTHCARE

from

Association of VA Psychologist Leaders
Association of VA Social Workers
Nurses Organization of Veterans Affairs
Veterans Affairs Physician Assistant Association
American Federation of Government Employees
National Federation of Federal Employees
National Association of Government Employees
National Nurses United
American Psychological Association
National Association of Social Workers

July 22, 2016

On June 30, 2016, the Commission on Care submitted its Final Report required by the Veterans Access, Choice, and Accountability Act of 2014.

As organizations comprised of and representing health care practitioners, researchers, educators, administrators and personnel devoted to serving Veterans, we have serious reservations about the report's major recommendation to replace the current VHA with a new entity, to be known as the VHA Care System. In the proposed VHA Care System, Veterans would be permitted to receive care from any local facility or provider who has been credentialed by VHA. Oversight for Veterans' health care would be handed over to a newly created, external governance board.

According to the Commissions' charter, "final recommendations will be data driven." As we demonstrate below, the recommendation to establish a new VHA Care System is at odds with compelling evidence of the VHA's current effectiveness. VHA can best serve Veterans by expanding access to services the VHA currently provides.

- The current VHA system provides health care that is as good as, and more often superior to, non-VA care. The Commission's Final Report affirmed this higher quality in VHA, as does RAND's 2015 evaluation (<http://www.rand.org/pubs/research—reports/RR1165z2.html>), RAND's 2016 summary (<http://www.rand.org/pubs/research—reports/RR1165z4.html>) and a 2016 literature review of 60 scientific publications (<http://bit.ly/1UOIEmF>). The VHA outperforms non-VA care on adherence to recommended preventative care guidelines, adherence to recommended treatment guidelines, outpatient processes and outpatient outcomes. Nevertheless, the Commission's Final Report ignores the implication that vastly expanding reliance on local non-VA providers and facilities could worsen, not improve, Veterans' health care.
- The proposed VHA Care System disassembles one of the most effective, innovative features of current VHA care - the Primary Care/Mental Health Integration approach. The Final Report concedes that such integration is largely missing in the community (p.22). Also absent in private sector health care are the inte-

grated, wrap around services the VA offers through financial, educational, housing, caregiver and employment support.

- The Final Report recognizes that VHA provides better coordinated care. “Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers” (page 28). It is the VHA, not the disjointed, larger non-VA system, which is the true provider of Veteran-centric community care.
- The Final Report anticipates that 60 percent of eligible care will shift from VHA facilities to outside networks (p.31). The net result will reduce, not expand, Veterans’ choices, since to pay for this shift, a VHA Care System will incrementally downsize the number of VHA providers and programs. The VHA system would be weakened.
- The Final Report estimates the cost of creating and implementing a new VHA Care System to range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion (p. 32). That’s \$11 billion more than the FY 2017 VHA medical care budget. If Congress saw fit to fund billions more yearly, there are better ways to strengthen the VHA, starting with expanded hiring at VA facilities where demand for services exceeds available staffing. But if Congress did not, the Final Report suggests that the expensive VHA Care System could offset costs by decreasing the number of Veterans eligible for VA health care, cutting services, or increasing Veterans’ out-of-pocket expenses. In any of those scenarios, Veterans are worse off.

In sum, given the evidence of overall quality, efficiency, integration and innovation within the VHA, we believe that efforts to reform the VHA can best serve Veterans by expanding access to services the VHA currently provides. Where geographic challenges exist and/or VHA does not offer specific services, the VHA should purchase services from non-VA partners.

Any proposed transformation of the VA health care system should be data driven. Don’t risk our Veterans’ health care on unproven ideas. We must preserve and strengthen the VHA integrated health care community that Veterans deserve and overwhelmingly prefer.

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Materials For The Record

LETTER FROM CHAIRMAN MILLER TO MARK TAKANO

September 8, 2016

The Honorable Mark Takano
Acting Ranking Member
House Committee on Veterans’ Affairs
333 Cannon House Office Building
Washington, DC 20515

Dear Acting Ranking Member Takano,

Yesterday, at the business meeting regarding the issuance of a subpoena for records pertaining to, among other things, the Administrative Investigation Board (AIB) report for the Aurora Replacement Medical Center construction project, you implied that only the Minority had concerns about VA mismanagement of the project and only the Minority was willing to withhold funding for its continuation. Specifically, you suggested that the Majority pushed through authorization “in the

middle of the night” by a voice vote “over the concerns of the Minority.” Nothing could be further from the truth.

A review of the two extenders bills increasing the authorization for the project from \$900 million to just over \$ 1 billion (S. 1568) and then again to \$1 .675 billion (S. 2082) show that both passed in the full light of day with strong bipartisan support. S. 1568 passed the House at 2:28 PM while S. 2082 passed at 3:08 PM, neither of which are remotely close to the middle of the night. Moreover, while S. 1568 passed the House without objection by unanimous consent, the yeas and nays for S. 2082 were taken resulting in a final vote of 423–0. The record includes your vote in favor of that authorization increase. See <http://clerk.house.gov/evs/2015/roll526.xml>.

Please also consult the Congressional Record related to S. 2082. See 161 Cong. Record 142, 1–16719-1-16727 (1st Sess., Sept. 30, 2015), <https://www.congress.gov/crec/2015/09/30/CREC-2015-09-30-pt1-PgH6719-4.pdf>. You will see that I expressed serious reservations about authorizing an additional \$625 million absent accountability by VA management and conditions on how the Department would cover the cost without jeopardizing medical care accounts. These concerns were reflected in the thoughtful remarks of our colleague Representative Dina Titus. You should also be aware that the authorization included a critical provision stripping VA of day-to-day management authority over super construction and transferring it to another federal entity, such as the Army Corps of Engineers.

Construction of the Aurora project has run \$1 billion over its original budget and has been the subject of ongoing outrage from members of both parties of this Committee. If there was a misunderstanding regarding your comments, please let me know. But, I felt it important to correct the record on such an important topic.

If you have any questions or concerns, please contact Jon Towers, Staff Director, at (202) 225-3527.

With warm personal regards, I am,

Sincerely

JEFF MILLER

Chairman

CJM/hr

LETTER FROM ROBERT A. MCDONALD TO PRESIDENT BARACK OBAMA

August 2, 2016

The Honorable Barack Obama
President
The White House
Washington, DC 20500

Dear Mr. President:

Two years ago, you tasked me to transform the Department of Veterans Affairs (VA) for the 21st Century. Since then, VA has established a comprehensive, enterprise-wide transformational process named MyVA, which has already increased Veterans’ access to health care and begun improving Veterans’ experience of VA’s benefits and services.

The direction we have taken and the progress we have made has been largely validated by the Commission on Care (Commission) in its Final Report, which VA received on July 7, 2016. After thoroughly reviewing the report, and receiving input from our Veterans Service Organizations (VSOs), I am pleased to say that 12 of the Commission’s 18 recommendations are objectives VA has already accomplished or has been working toward for the past two years as part of the MyVA transformation. Although we differ with the Commission on some details and are pursuing alternative approaches where warranted, we agree with the Commission that many changes planned by MyVA, recommended by the Commission, and strongly supported by VSOs, will likely require resources and remedies that only Congress can provide. These issues and our many transformation efforts are summarized in the enclosure to this letter.

VA strongly disagrees with the Commission on its proposed “board of directors” to run the Veterans Health Administration (VHA). Such a board is neither feasible nor advisable for both constitutional and practical reasons. The U.S. Department of Justice has concluded that the Constitution prevents Congress from appointing per-

sons to exercise authority over Executive branch agencies and as such, would prevent the proposed board from exercising the authorities assigned to it by the Commission. The Commission's proposal would also seem to establish VHA as an independent agency, undoing the work of the VSOs in creating VA as a Cabinet-level department. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health, as well as weaken ownership of the MyVA transformation and VHA performance. This could potentially disrupt and degrade VA's implementation of critical care decisions that affect Veterans. The proposed independent VHA agency would also run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services provided to Veterans by the Veterans Benefits Administration and the National Cemetery Administration.

At present, VA is served by 25 advisory Committees, including a newly reconstituted Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and a newly established MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates. These advisory Committees advise VA on strategic direction, facilitate decision making, and introduce innovative business approaches from the public and private sectors. With their help, the Department has begun the process of transforming VHA from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services and additional choice, but without sacrificing VA's foundational health services upon which many Veterans depend. Additionally, many VSOs fear that the Commission's vision would compromise VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, post-traumatic stress disorder, and other mental health needs, which the private sector is not as equipped to provide.

In October 2015, VA submitted to Congress our Plan to Consolidate Community Care, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership and clinicians, representing diverse groups and backgrounds. VA has already begun what work we can without legislation to make the plan a reality. Over the course of the last 12 months, our Choice Provider network has grown by 85 percent. The network now has over 350,000 providers and facilities across the Nation. Over 930,000 unique Veterans have used the Veterans Choice Program (VCP). Over 100,000 Veterans with 40-mile eligibility used VCP through May 2016. Authorizations for care under the Veterans Access, Choice, and Accountability Act (VACAA) have increased by 82 percent over 9 months (October 2015 to June 2016), and VCP authorizations have quadrupled from approximately 380,000 in fiscal year (FY) 2015 to almost 2 million in FY 2016.

However, VA cannot accomplish the ongoing transformation through MyVA or recommend by the Commission without critical legislative changes and funding. VA has aggressively pursued these needed changes and funding. As you know, more than 100 legislative proposals for Veterans were included in your 2017 Budget. Many of these proposals are vital to maintaining our ability to purchase community care. We continue to work to move these critical initiatives forward and are encouraged by the fact that most have been considered in legislative hearings or included in omnibus bills moving towards floor consideration, like the bipartisan Veterans First Act, which passed the Senate Veterans Affairs' Committee unanimously. These bills include some of the provisions of the Purchased Health Care Streamlining and Modernization Act we submitted to Congress in May 2015, such as an enhanced-use lease authority, compensation reform for medical professionals, and a measure of budgetary flexibility to respond to Veterans emerging needs and overcome artificial funding restrictions on providing Veterans care and benefits. These provisions would go a long way toward ensuring the success of MyVA, but other important legislative issues still need to be addressed, especially the consolidation of VA's many purchased care authorities and modernization of VA's archaic claims appeals process.

Your strong support for Veterans has been critical to the progress made so far, but VA needs Congress' assistance to make the transformation intended by the Commission and already underway in MyVA to accomplish the changes needed to serve Veterans as the need and deserve to be served now and for generations to come.

Thank you for your continued support of our Nation's Veterans.

Sincerely,

Robert A. McDonald

**Enclosure
August 2016**

DEPARTMENT OF VETERANS AFFAIRS

REVIEW OF THE COMMISSION ON CARE

Over the past two years, the Department of Veterans Affairs (VA) has been working energetically, through its MyVA initiative, to transform the Veterans Health Administration (VHA) from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services, plus more choice, but without sacrificing VA's foundational health services that many Veterans depend on.

In October 2015, VA delivered to Congress a plan for evolving our current system into a high-performance network based on timely access to foundational services and integration of private-sector providers. Building on more than a decade of working with community partners through multiple mechanisms, this plan would consolidate the various mechanisms, expand our network of providers, and enhance the network's capability to deliver services essential to Veterans' health.

Many of the Commission on Care's (Commission) recommendations are aimed in the same direction and are already being implemented as part of VHA's MyVA transformation. VA finds 15 of 18 Commission recommendations feasible and advisable (#1-3, 5-8, 10-16, and 18) and 3 not feasible or advisable (#4, 9, and 17). VA is already implementing changes with the same intent as 12 recommendations (#1-3, 5, 7-8, 10-11, and 13-16); recommends alternative approaches to 2 recommendations to bring them in line with other MyVA reforms (#6 and 12); and will work with the President, Congress, Veterans Service Organizations, and other stakeholders on recommendation #18.

Many of the Commission's recommendations also require action by Congress. VA has aggressively pursued legislative changes and funding that would enable VA to achieve its MyVA vision. More than 100 proposals for legislative changes were included in the President's 2017 Budget. VA also submitted to Congress in May 2015 the Purchased Health Care Streamlining and Modernization Act, parts of which have been incorporated into the Veterans First Act in the Senate. Many of VA's proposals, which are vital to maintaining our ability to purchase non-VA care, are pending Congressional action.

Recommendation #1: VHA Care System

"Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which Veterans will access high-quality health care services."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach to achieve the vision described above.

In October 2015, VA submitted to Congress its Plan to Consolidate Community Care, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds.

Immediate steps to improve the stakeholder experience were identified and included in the plan, including reducing unnecessary steps in the processes to enroll and connect Veterans with community care; improving communications between VHA, provider, and Veterans; improving care coordination in the long term for Veterans through improved exchange of certain medical records; and aligning the Veteran's community care journey along five major touch points: eligibility, community care network, referral and authorization, care coordination, and provider claims payment.

Eligibility: The Plan recommends the creation of eligibility criteria to streamline the many different requirements for community care into standard criteria without opening community care to all enrolled Veterans. This is VA's principal point of difference with the Commission on its proposed VHA Care System. VA believes the Commission's recommendation to extend community-care eligibility to all Veterans by eliminating the Veteran Choice Program's (VCP) current time and distance cri-

teria (30 days and 40 miles) is not advisable without Congressional funding due to the expected cost increase and desire to not sacrifice VA's four statutory missions: delivering hospital care and medical services to Veterans, educating and training health professionals, conducting medical and prosthetic research, and providing contingency support to other Federal agencies during emergencies. Many VSOs fear that the Commission's vision would jeopardize VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, posttraumatic stress disorder (PTSD), and other mental health needs, which the private sector is not as equipped to provide. For this reason, VA opposes elimination of the current time and distance criteria.

Community Care Network: VA has since begun developing the requirements for the new community-care network contract, with standards and criteria developed from input by industry, facility staff, and program office staff representing a broad spectrum of needs. These standards and criteria will be included in the draft Request for Proposal (RFP) for the community care network that will open for bid later in calendar year 2016. Legislation is needed to improve Veterans experience by consolidating existing programs and standardizing eligibility criteria.

Referral and Authorization: To ensure that Veterans have access to the full spectrum of health care services, VA will focus on areas in which it can excel (VA-delivered foundational health services) and develop locally defined community partnerships for specialty care as needed. Standards and criteria for specialty care referrals are currently being developed for inclusion in the draft RFP. While the primary care provider will coordinate referrals for specialty care within the integrated VHA Care System, VA should be seen as the prime provider for special emphasis services. For example, VA is the leader in integrating primary care and mental health care and should be seen as the primary care provider for these services. When VA cannot provide a primary care provider, Veterans will be able to select from credentialed providers in the high-performing network.

Care Coordination: The Plan stresses care coordination with a focus on customer service, emphasizing the need for care coordination for Veterans who receive community care as well as in VA. This coordination would include both the primary care provider staff as well as other VA staff. In cases where VA cannot provide the care coordination for Veterans, the services may be provided through the community care network. In other cases, VA coordinators make more sense. This is true in the Alaska VA Healthcare System, where VA staff will fill an intermediary role currently performed by VCP contractor TriWest to make scheduling an inherently VA activity, in response to local concern that calling out-of-state VCP contractors resulted in delays in care coordination, mostly attributed to time-zone differences and a lack of understanding of Alaska's unique geography.

Provider Claims Payment: VHA is also already working to streamline reimbursement methodologies among its various community care programs and to develop a standardized, transparent process for reimbursing providers in an integrated delivery network. VHA and the Centers for Medical and Medicaid Services (CMS) are identifying CMS innovations in value-based payment methods on a limited basis. Legislation is needed to revise reimbursement rates under the Veterans Access, Choice, and Accountability Act to allow for flexibility from Medicare fee-for-service reimbursement methodologies to value-based methodologies of the future.

Legislation is needed to effectively consolidate existing community care programs, which would reduce confusion among Veterans, community providers, and VA staff. The Commission states that in order to achieve the recommendations, VA must have "flexible and smart procurement policies and contracting authorities." VA strongly agrees and has aggressively pursued legislative changes that would ensure that the appropriate level of flexibility is available to best serve Veterans. In May 2015, VA submitted the Purchased Health Care Streamlining and Modernization Act to Congress. This legislation supports key points of VA's Plan to Consolidate Community Care and would allow VA to enter into agreements with individual community providers outside of Federal Acquisition Regulations, without forcing providers to meet excessive compliance burdens.

VA is also concerned that the Commission's cost estimates do not accurately reflect the likely cost of its proposed system. From a baseline estimate of \$71 billion, the Commission estimates that the cost of its recommended option for Veterans' health care for fiscal year (FY) 2019 ranges from \$65 billion to \$85 billion, with a middle estimate of \$76 billion. However, the Commission estimates the cost could increase to \$106 billion in FY 2019 if VA is unsuccessful in tightly managing the network and focusing on costs. We appreciate the analysis underpinning the Commission's estimates, but caution that the cost of implementing the Commission's recommendation is likely to be significantly higher, for the following reasons:

- The estimates do not include the substantial investment in information technology (IT) resources that would be required to fully integrate VA care with community care or the administrative/contractual costs of operating the community-delivered services component of the integrated network.
- The estimates assume that VA can realign and consolidate personnel in five years to best provide health care to Veterans, which is an aggressive timeline.
- The estimates do not address the cost of realigning or divesting capital assets as additional care is delivered in the community. While VA agrees in principle with the Commission's recommendation to develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs (see Recommendation #6), we note that the realignment, consolidation, and divestiture of capital assets will require substantial resources and time.
- The estimates are highly dependent on Veteran enrollment in, reliance on, and utilization of VA health care, all of which are difficult to predict, as most Veterans enrolled in the VA health care system have other sources of health care coverage. Extending community care to more Veterans could cause Veterans who now rely on Medicare, Medicaid, or private insurance to use VA care for more of their health care needs because of lower copays or greater convenience, increasing VA's costs.
- Finally, we must caution that the estimates do not reflect the entire VA Medical Care budget as they do not include the cost of programs that are not modeled by the VA Enrollee Health Care Projection Model. These programs include readjustment counseling, non-medical homeless programs, Caregivers, Health Professions Educational Assistance Program, Income Verification Match, CHAMPVA, Spina Bifida, Children of Women Vietnam Veterans, etc. In total, they are estimated to cost \$8.2 billion in FY 2017.

Recommendation #2: Enhancing Clinical Operations

"Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is already engaged in processes to make full use of the skills held by VHA providers and other health professionals. VHA is a leader in the use of clinical pharmacists to increase capacity by renewing prescriptions or ordering medication refills independently, after the initial prescription by a licensed physician or nurse practitioner. In addition, many VA clinical pharmacists have a scope of practice that provides prescribing authority and enables them to run pharmacist-managed clinics focused on medication therapy management for chronic diseases. For example, about one third of all prescriptions for the treatment of the Hepatitis C virus are written by clinical pharmacists.

VHA has also developed a draft regulation that would standardize full practice authority for advanced practice nurses, to assure a consistent continuum of health care services by the practitioners across VHA and decrease the variability in advanced nurse practice that currently exists as a result of disparate State practice regulations. The proposed draft regulation was published in the Federal Register; we are now reviewing comments received. Implementation of full practice authority will increase Veteran access by alleviating the effects of national health care provider shortages on VA staffing levels and enabling VA to provide additional health care services in medically under-served areas. Implementing this policy, as recommended by the Commission, will allow VA to parallel the policies of other Federal agencies, including the Department of Defense (DoD) and the Indian Health Service, as well as many institutions in the private sector.

VHA's Diffusion of Excellence initiative is an operational infrastructure that allows for sharing of promising practices across the enterprise. This model incentivizes and institutionalizes the identification and diffusion of practices nationwide so that every facility has the opportunity to implement the solutions that are most relevant to them. In the first round of submissions, 13 Gold Status Best Practices were selected from more than 250 ideas through a series of reviews and a final "Shark Tank" competition. The next step assigned each Gold Status Best Practice and their originating Gold Status Fellows to Action Teams managed by the Diffusion Council for implementation VHA-wide.

VA seconds the Commission's call for Congress to relieve VHA of bed-closure reporting requirements under the Millennium Act. The Act's arbitrary requirements have not kept up with changes in the Veteran population or the health care environment. Legislation is needed to remove the Act's bed change reporting codified at 38 U.S.C. 8110(d) and the staffing level and service requirements specific to such bed

changes under section 38 U.S.C. 1710B(b), while retaining staffing and service requirements for all other Extended Care Services. VA would replace the mandated congressional reporting of bed closures with a stronger, clearer, and more stringent internal process to review and if appropriate, approve bed closure proposals.

VA is already moving forward to hire and train more clinical managers and medical support assistants (MSAs). In response to Section 303 of the Veterans Access, Choice, and Accountability Act of 2014 (PL 113–146), each VA Medical Center now has a Group Practice Manager (clinical manager). Additional hiring and training of these group practice managers will continue through February 2017. VHA is also developing new training and hiring procedures for MSAs throughout the organization as part of MyVA. VA has developed and launched an MSA hiring project called “Hire Right, Hire Fast” and is currently piloting a new hiring procedure that allows for industry-standard bulk hiring of MSAs to hire MSAs within 30 days of a vacancy. Two-week, standardized onboarding training for all new MSAs is also being developed and piloted. Both new processes will begin being deployed nationally this fall.

Recommendation #3: Appealing Clinical Decisions

“Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach, taking into account important differences between the mission and authority of the VA health care system and other Federally-supported programs.

VHA is already in the early stages of developing a regulation in response to the Commission’s recommendation. This regulation will establish a cohesive baseline national policy for clinical appeals. A clinical appeals regulation will be published for notice and comment in accordance with the Administrative Procedure Act. Recently enacted legislation in section 924 of the Comprehensive Addiction and Recovery Act of 2016 establishes an Office of Patient Advocacy in the Office of the Under Secretary for Health. In addition, in 2015 VHA established the Office of Client Relations to assist Veterans clinical care access concerns.

An interdisciplinary panel will be tasked with evaluating feedback from these offices and other Veteran support resources to improve the overall clinical appeals process, consistent with external benchmarks and factors described by the Commission, Federal regulations and statutes, and sound clinical practice. The resulting recommendations may differ in certain aspects from those envisioned by the Commission, but will undoubtedly be a uniform, fair, world-class clinical appeals process that protects Veterans and is fully compliant with law and regulation. VA’s revised process will complement the Veterans Experience Office’s efforts to better serve Veterans, make improvements based on customer feedback, and engage the community.

Recommendation #4: Consolidation of Improvement Efforts

“Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.”

VA finds this recommendation neither feasible nor advisable, but is already implementing an alternative approach that institutionalizes continuous improvement as part of VA’s MyVA transformation.

Health care improvement takes place within a complex socio-technical system with multiple aspects of technology and technical expertise. Placing improvement under an engineering system, such as the Veterans Engineering Resource Center (VERC), may harness the technical aspects of improvement, but it will not provide the balance of critical cultural and people aspects. VA believes doing so would unbalance safety and efficiency and not be successfully transformational.

Ongoing VA transformation efforts have been achieved by specifically aligning VERC assets with enterprise priorities so that appropriate engineering perspectives and skills are interwoven with current organizational priorities. To institutionalize VHA’s commitment to continuous improvement, VHA will realign the VERC and the operational improvement arm of Strategic Analytics for Improvement and Learning (SAIL) under the Principal Deputy Under Secretary for Health. This will elevate the health-system subject matter experts who drive transformation in VHA’s organizational structure, while continuing to use the VERC to ensure that supporting engineering resources are available across all VA transformational efforts.

Additionally, VA’s enterprise approach to improving performance-through Lean Six Sigma (Lean) tools and training, Leaders Developing Leaders training, MyVA

Performance Improvement Teams, MyVA Communities, the MyVA Ideas House, and many other initiatives across the VA system has taught us the value of a central repository for local programs and ideas, both successful and unsuccessful. To that end, VA and VHA have embraced the Integrated Operations Platform (IOP) hub, a knowledge-management technology platform developed by the VERC in partnership with subject matter experts. The IOP consolidates information on continuous improvement activities across VA in key programs, and as a result, best practices and innovation activities are currently visible in one common platform.

VA has invested significantly in developing Lean capacity at local levels so that problem solving is done at the lowest level and with a team of safety, quality, and improvement professionals. This prepares the local facilities to improve their current environment while scanning constantly for emergent new problems.

Recommendation #5: Eliminating Healthcare Disparities

“Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.”

VA finds this recommendation feasible and advisable and is already working to address each of the Commission’s concerns as part of VA’s MyVA transformation.

VA’s Office of Health Equity (OHE) was established in 2012 with the mission of championing health equity among vulnerable Veterans. The office developed the Health Equity Action Plan (HEAP) in 2014 in conjunction with the Health Equity Coalition and with concurrence from the Under Secretary for Health. The HEAP is VHA’s strategic roadmap to reducing Veteran health disparities. It aligns with the goals of MyVA and the VHA Strategic Plan. VHA will make health equity a priority by directing implementation of the HEAP nationwide.

The appropriate placement of OHE within the VHA organizational structure, along with adequate resources, will be considered as a priority component of the broader VHA restructuring addressed in Recommendation 12. This will take into account funding and staffing levels commensurate with the scope and size of Federal offices of health equity established in the Department of Health and Human Services, based on direction in the Affordable Care Act. VA will also identify health equity leaders and clinical champions in each VA District, Veteran Integrated Service Network (VISN), and Medical facility who can catalyze and monitor actions to implement the HEAP and further advance the elimination of health disparities.

VA has undertaken systematic actions to identify and address health care disparities and inequality. Examples include the development of Hepatitis C Virus Disparities dashboard projected, scheduled for launch by the end of FY 2016; data support and research collaborations with the Quality Enhancement Research Initiative designed to identify health care disparities; establishment of a Population Health office that has developed clinical case registries focusing on the needs of special populations; and establishment of the Women’s Health and Lesbian, Gay, Bisexual, Transgender (LGBT) program offices. VA Medical Facilities constitute 20 percent of Human Rights Campaign’s Health Care Equality Index participants in 2016, and they were the only facilities to achieve leader status in some States.

Recommendation #6: Facilities and Capital Assets

“Develop and implement a robust strategy for meeting and managing VHA’s facility and capital asset needs.”

VA finds this recommendation feasible and advisable but recommends alternative approaches as part of VA’s MyVA transformation.

VA believes that the Commission’s recommendation is critical to enabling the successful transformation of the large-scale health care system to a higher-performing integrated network to serve Veterans. Without a strong suite of capital planning programs, tools, and resources, VA will not be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated health care network. VA also strongly agrees with the Commission that greater budgetary flexibility and greater statutory authority are essential to meeting VA’s facility needs, realigning VA’s capital assets, and streamlining processes to divest itself of unneeded buildings.

VA recommends alternative approaches to two issues:

- Once VA determines its mix of health care services and how they are provided at the market level based on the integrated health care approach, realignment of VA’s capital infrastructure framework will be needed. Instead of a realignment process encompassing both assets and services based on DoD’s Base Realignment and Closure Commission, VA proposes an independent facilities re-

alignment commission (IFRC) to focus solely on VA's infrastructure needs once the mission services are determined. The IFRC would develop a systematic capital-asset-focused realignment plan for infrastructure needs to be presented to the Secretary of Veterans Affairs and the President for decision, with Congress approving or disapproving the plan on an up-or-down vote.

- With regard to focusing new capital on ambulatory care development, VA proposes a balanced approach to maintain needed infrastructure and other key services (e.g., rehabilitation, community living centers, and treatment for spinal cord injury, traumatic brain injury, polytrauma, and PTSD), while at the same time appropriately investing in ambulatory care in needed markets. The balanced approach would be based on a market-by-market determination of the appropriate mix of services to ensure Veterans have access to needed care.

VA agrees with the recommendation to move forward immediately with repurposing or disposing facilities that have already been identified as being in need of closing. Continued focus in this area is needed and VA is already working towards this goal, subject to the availability of staff and resources.

VA also acknowledges that there will be anticipated challenges in implementing such large-scale realignments and restructuring of VA's footprint. Legislation will likely be required facilitating changes to VA's capital infrastructure to implement a transformation of this nature, including:

- Establishing an IFRC to develop a systematic capital-asset-focused realignment plan.
- Streamlining processes to meet the intent of laws and regulations, such as the National Historic Preservation Act and the National Environmental Policy Act that would make repurposing and divestiture more timely and effective.
- Potentially restructuring appropriations to allow for more flexible transfer and reprogramming authority, including potential threshold adjustments.
- Exploring methods (both legislative and administrative) to take advantage of private-sector financing.
- Revising the major medical lease authorization process to align the requirements in concert with practices at other Federal agencies.
- Granting VA authority to retain and utilize proceeds generated from real property divestitures.
- Expanding enhanced-use leasing authority.

Further analysis will be required to determine the specific level of resource investments required to implement the Commission's recommendations. It is clear that significant additional resources will be required. In addition, divestiture of unneeded VA assets is unlikely to generate significant savings because of the upfront resources required to execute the divestiture and minimal market value of the majority of VA's assets. Without the proper resources, tools, and authorities, attempts to divest of assets or streamline capital project execution will not be effective.

Recommendation #7: Modernizing IT Systems

“Modernize VA’s IT systems and infrastructure to improve veterans’ health and well-being and provide the foundation needed to transform VHA’s clinical and business processes.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach, understanding that investments in IT will force difficult decisions concerning the allocation of limited financial resources among all VA programs and services, as well as across the Federal government.

As part of the MyVA Breakthrough Initiative to transform VA IT, VA will soon appoint a Senior Executive System (SES)-equivalent position for a Chief Health Informatics Officer (CHIO), reporting to the Assistant Deputy Undersecretary for Health for Informatics and Information, to collaborate with the VA Chief Information Officer (CIO) and the IT Account Manager toward developing a comprehensive health IT strategy and supporting budget proposal. The CHIO and ADUSH will be responsible for prioritizing all health technology programs and initiatives, with strategic technological guidance from the VA CIO and IT Account Manager for health. To comply with the Federal Information Technology Acquisition Reform Act (FITARA), the CHIO does not take the place of the VA CIO, but instead works in concert with IT management to ensure that health initiatives are appropriately prioritized within the portfolio, while the CIO works with VA senior leadership so that all technology initiatives are prioritized holistically, thus ensuring complete Veteran care. VHA and VA's Office of Information and Technology (OI&T) are al-

ready collaborating on the vision and strategy for a single integrated Digital Health Platform (DHP).

VA has also established five district senior-executive Customer Relationship Manager positions to work with the local VHA, Veterans Benefits Administration, National Cemetery Administration, and staff office leaders, aggregate feedback for analysis by VHA and OI&T senior leadership, and enhance a continuous feedback loop. The VA CIO recently established the Veteran-focused Integration Process program within the Enterprise Program Management Office (EPMO) to facilitate continuous improvement and constant collaboration.

The Commission recommended that the VA CIO develop and implement a strategy to allow the current nonstandard data to effectively roll into a new system, and engage clinical end-users and internal experts in the procurement and transition process. VHA is currently working with OI&T to ensure that the Veterans Information Systems and Technology Architecture (VISTA) data is mapped to national standards. The new CHIO will be responsible for engaging clinical end-users in the transition to the new DHP. The Under Secretary for Health and the CIO will establish a joint program office responsible for the implementation of the DHP. This process will be focused on delivering and coordinating high-quality care for Veterans.

The EPMO is responsible for portfolio management and has adopted a policy of “best-fit, buy-first” in its Strategic Sourcing function. This ensures that existing best-in-class technology solutions are purchased whenever possible, rather than being developed and maintained by VA. These functions, in combination with the role and focus of the IT Account Manager, will provide the required focus for VHA to implement a comprehensive commercial off-the-shelf IT solution to include clinical, operational, and financial systems.

Recommendation #8: Modernizing Supply Chain

“Transform the management of the supply chain in VHA.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach.

VA believes the components of this recommendation that suggest establishment of a Chief Supply Chain Officer (CSCO) and realignment of all procurement and logistics operations under the CSCO executive position are feasible and advisable, but it recommends an alternative approach to fulfill the Commission’s intent. The structural solution recommended by the Commission would not adequately address underlying management challenges associated with organizational complexity and the need to improve integration processes impacting the supply chain. Realignment of VHA’s supply-chain structure, including roles and responsibilities of the various VA Central Office staff offices, health networks, and medical facilities, should derive from and be integrated with the transformation of the overall VHA health care organization structure. The intent of the Commission will be met by addressing alignment issues as the supply-chain breakthrough initiative evolves and is synchronized with VHA’s overarching strategies to transform VHA’s organizational structure.

As an alternative, the intent of the Commission is already being addressed in an effective manner under the current MyVA Breakthrough Initiative to transform VHA’s supply chain. This initiative is a more comprehensive approach to fulfilling the Commission’s intent and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in FY 2016, VHA supply-chain transformation efforts have yielded approximately \$45 million in cost avoidance. VHA has also developed a two-year supply-chain transformation stabilization guidance that will put VHA in a far better position to make effective decisions and investments beyond FY 2018 for vertically aligning VHA’s management structure and for more efficient sourcing and distribution of all clinical supplies and medical devices. This will increase the availability of supplies for the care of Veterans and result in cost avoidance for American taxpayers.

With regard to the component of the recommendation asking VA and VHA to establish an integrated IT system to support business functions and supply-chain management, although feasible it is more advisable that technology investments beyond those currently in the pipeline should be avoided until such time that a mature supply-chain baseline is established, upon which prudent future IT investment decisions can be based. This is especially important given VA’s Financial Modernization System initiative and emerging plans for a new DHP, both of which will impact legacy and contemporary supply-chain systems and interfaces, as well as influence system-improvement alternatives and investment decisions over the next two to five years. Supply-chain system improvements must be integrated and synchronized with enterprise financial and health care system enhancements to achieve effi-

ciencies in service delivery and support analysis of integrated data to meet VHA's current and future needs.

Finally, as suggested, VHA will continue to use VERC capabilities to support the transformation of supply-chain management in accordance with the MyVA Breakthrough Priority Initiative #12: VHA Supply Chain Transformation. As a point of clarification, the Commission report is technically incorrect in that the VERC is not leading the MyVA supply-chain modernization initiative; rather, the VERC is a highly valued enabling organization engaged by the VHA Procurement and Logistics Office to support the MyVA initiative.

Recommendation #9: Governance Board

“Establish a board of directors to provide overall Veterans Health Administration (VHA) Care System governance, set long-term strategy, and direct and oversee the transformation process.”

VA finds the Commission's recommendation neither feasible nor advisable due to its unconstitutionality. However, VA believes the intent of the Commission can be achieved regarding the term appointment of the Under Secretary for Health.

The U.S. Department of Justice has concluded that the proposed board of directors, as appointed and with the powers proposed by the Commission, would be unconstitutional for several reasons. Permitting Congress to appoint the board members would violate the Constitution's Appointments Clause (U.S. Const. art. II § 2, cl. 2), as well as the separation of powers, insofar as congressionally appointed board members would be exercising significant operational authorities within the Executive Branch. In addition, giving this board authority to reappoint the Under Secretary for Health would violate the Appointments Clause and the separation of powers. Finally, requiring the board to concur with the President in removing the Under Secretary for Health would give the board a veto authority over the President, impairing the President's ability to “take Care that the Laws be faithfully executed.” (U.S. Const. art. II, § 3), and violating the separation of powers.

The proposed board would also seem to separate VHA from VA without necessarily insulating VHA from political pressure or improving VHA oversight or operations. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health and weaken ownership of the MyVA transformation and VHA performance, potentially disrupting and degrading VA's implementation of critical care decisions affecting Veterans. The independence granted VHA would run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services VA provides through the Veterans Benefits Administration and the National Cemetery Administration. Furthermore, VA is already advised by the Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and by the MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates with diverse expertise in customer service, strategy development and implementation, business operations, capital asset planning, health care management, and Veterans' issues. These Committees already provide VA with outside expert advice on strategic direction, facilitating decision making and introducing innovative business approaches from the public and private sectors.

The Commission correctly notes that frequent turnover of the Under Secretary for Health has had a negative impact on VHA and greater stability in this important leadership position is needed. VA supports a term appointment of the Under Secretary for Health spanning Presidential transitions to ensure continuity of leadership and continued transformation of VHA. Previously, 38 U.S.C. § 305 provided for a four-year term for the Under Secretary for Health with reappointment possible, but this provision was removed in 2006. A term appointment could be reinstated, beginning with the current Under Secretary for Health. This is critically important at this juncture given the need to see the ongoing transformation of VHA through to completion. Under Secretary for Health candidates are currently recommended by a commission established solely for that purpose. More analysis is needed to determine length of tenure and timing of reappointment.

Recommendation #10: Leadership Focus

“Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

Recent or ongoing actions serving the Commission's intent include:

- VA has established the MyVA Task Force to guide VA through the transformation and established a Department-wide MyVA transformation office, which has formulated an integrated plan for transformation and is organizing the work on 12 breakthrough priorities.
- Metrics and key performance indicators are in place for each breakthrough priority. Each breakthrough priority has a designated, accountable official who is a member of the senior leadership team and a near-full-time responsible official in charge of driving progress.
- One of the 12 breakthrough priorities in the MyVA Transformation is employee engagement, for which we have a comprehensive action plan.
- VA has also established a MyVA Advisory Committee (MVAC) consisting of business leaders, medical professionals, government executives, and Veteran advocates. VA leadership meets quarterly with the MVAC, leveraging them as a corporate board from which to seek counsel on the overall transformation.
- MyVA has engaged leaders and employees throughout the organization via Leaders Developing Leaders (LDL) (over 54,000 participants to date), VA101 (over 79,000 participants to date), various skills trainings, LDL projects, breakthrough pilots, broad communications to include the MyVA Story of the Week that goes out every Friday to all employees, and local initiatives.
- VA established MyVA district offices to facilitate transformation efforts throughout VA and also now conducts quarterly surveys of the VA workforce and incorporates this feedback into VA's transformation actions.
- Secretary, Deputy Secretary, and Under Secretary for Health have provided role models for transparency, Veteran focus, and principles-based leadership.
- VHA programs and program offices and the Office Human Resources & Administration (HR&A) representatives have held regular meetings in the past year to discuss a single, benchmarked concept for organizational health and coordinate messaging.
- VHA's National Leadership Council has endorsed personalized, proactive, patient-driven health care as one of VHA's strategic goals and strongly supported the formation of organizational health councils.
- Many VHA facilities and networks have some version of an organizational health council already existing.
- All program offices and facilities receive employee survey data annually down to the workgroup level to facilitate action planning and improve employee engagement. Brief pulse surveys have recently been implemented to measure employee engagement at the facility level quarterly.
- VHA's National Center for Organizational Development has use of Prosci change management materials and is pursuing a system-wide license.

Recommendation #11: Leadership Succession

“Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VA is consolidating leadership training behind a model we created as part of our MyVA transformation called ILEAD. Previously, VA had multiple leadership models across VA, which led to no common language or culture of leadership, and the models were not customized for VA. The enterprise-wide ILEAD model will incorporate the principles of “servant leadership” and VA's ICARE core values, aligned with the Federal Executive Core Qualifications. VHA and the VA Corporate Senior Executive Management Office are in the first stages of developing a competency model for VHA's senior leadership positions that will incorporate VA's ILEAD model with the technical competencies essential to successfully leading VHA's complex clinical operations. The VHA senior leader competency models will ultimately cascade down through the organization and be incorporated in its hiring, development, performance assessment, and advancement programs.

VHA has outlined a leadership talent management strategy, benchmarked against the best practices in private industry, and begun initial development of processes and tools to give VHA greater insight and control over its health care leadership succession pipeline. Initial efforts are focused on creating a cadre of leaders to fill future medical center director positions. At the individual level, VHA senior executives serve as mentors to staff members, coaches for VHA leadership development programs, and models through their own leadership behavior.

Current VHA initiatives serving the Commission's intent include:

- VHA made leadership development a priority of its MyVA effort, specifically to develop and retain passionate leaders to lead transformational efforts across the Administration.
- Filling key leadership position through a strong succession pipeline is identified as a priority for VHA in the 2016 VHA Workforce and Succession Strategic Plan.
- VHA has fully embraced the LDL philosophy-nearly 30,000 VHA employees have participated in the leader-led cascaded training since it began in September 2015.
- VHA's National Leadership Council has adopted the VA leadership model, which now includes the concept of "servant leader."
- VHA leaders are integrally involved in the development and conduct of its formal leadership development programs. Leaders serve as coaches and mentors to program participants, in addition to personally facilitating sessions on a wide variety of leadership topics.
- VHA established the Healthcare Leadership Talent Institute (HLTI) to provide coordinated focus to VHA's talent management efforts. HLTI links VHA's workforce-planning and talent-development programs through the design and deployment of a set of talent management products and processes, which are in the pilot-testing phase.
- VHA is collaborating with the VA Corporate Senior Executive Management Office in implementing the December 2015 Executive Order on Strengthening the SES. These efforts include building a foundational leadership competency model for VA, instituting an executive rotation program to provide career-broadening experiences outside of each executive's current position, enhancing the SES performance management system, and outlining an SES-level talent-management process for VA-wide implementation.

Recommendation #12: Organizational Structures and Management Processes

"Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices."

VA finds this recommendation feasible and advisable but recommends an alternative approach to reorganizing the VHA Central Office (VHACO), consistent with VA's MyVA transformation.

VHACO has undergone a stepwise ascent to improving the organizational structure to be more responsive to field requirements through the development of large programs responsible for organizational excellence and developing the future state health care plan. Immediate reorganization would divert attention from key organizational priorities such as improving access to health care. Known challenges associated with reorganization (which occurs with the regularity of each presidential election cycle), are impaired employee engagement, loss of institutional knowledge, and diversion of attention from critical challenges such as insuring Veterans have same-day access to primary care and mental health care services. Legislation would be required to streamline appropriations, and review by oversight bodies would be impacted by the changes described. Finally, the reorganization for VHACO should derive from and be integrated with the transformation of the overall VHA health care organization structure. VHA will initiate a VHACO and VISN organization analysis at the beginning of calendar year 2017.

Recommendation #13: Performance Measurement

"Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is consolidating its health care operations metrics to provide a consistent, system-wide view of key performance indicators. In October 2015, VHA launched a Performance Accountability Work Group (PAWG) as a governance mechanism for performance measurement at all levels of the organization. The PAWG's first task was to conduct a systematic review of all existing performance measures (num-

bering over 500), which resulted in a core set of approximately 20 key indicators, aligned to industry-wide approaches. SAIL scoring system is a critical component of these indicators, as well as predictive trigger systems that are the main inputs into a health operations center, which will facilitate centralized quality management.

The leadership of the Office of Organizational Excellence (hereafter, 10E) has undertaken a strategic review across all current business processes to identify realignment opportunities—for instance, focusing ISO 9000 on its original target, which was the reprocessing of reusable medical equipment, and reinvesting the resources that will be freed up to enhance the ability of VERC to support the adoption of LEAN management approaches in support of the Under Secretary for Health's five priorities for strategic action.

We have also engaged a senior industry consultant to assist us with the process of executive recruitment and development; created a system-level VHA Performance Scorecard aligned along transformational priorities; simplified the template used for senior health care executive performance management plans; and started work to align business functions within the Office of Organizational Excellence to promote a unified approach to performance reporting, performance improvement, and the identification and spread of strong clinical and business practices.

Finally, the Diffusion of Excellence initiative (see Recommendation #2) sources best practices from frontline employees in the field, and brings the combined resources of 10E to support their implementation where appropriate in under-performing VA sites.

Recommendation #14: Cultural and Military Competence

“Foster cultural and military competence among all Veterans Health Administration (VHA) Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health care outcomes.”

VA finds this recommendation feasible and advisable and is already working to address the Commission's concern as part of VA's MyVA transformation.

VA has implemented training related to cultural and military competence, in some cases by partnering with external stakeholders (i.e., Equal Employment Opportunity Commission, the Joint Commission, Commission on Accredited Rehabilitation Facilities, DoD) and numerous national diversity-focused affinity and advocacy organizations. Examples of this coordinated training include Military Culture Training for Community Providers, Cultural Competency, Generational Diversity, Introduction to Military Ethos, Military Organization and Roles, Professional Stressors & Resources and Treatment Resources & Tools. From April 1, 2015, to July 22, 2016, the last four courses were accessed 2,533, 1,527, 1,172, and 1,070 times respectively. VA will continually assess its cultural and military competence training portfolio for content, target audience, and training modalities to identify additional training needs.

VA Office of Diversity and Inclusion has mandatory training in the area of cultural competence as part of its Equal Employment Opportunity (EEO), Diversity and Inclusion, and Conflict Management training for all VA managers and supervisors and mandatory annual EEO, Workplace Harassment, and No FEAR training for all VA employees. VA also maintains programs focusing on targeted populations, including a LGBT Awareness Program (issues referenced in the Report), Office of Women's Health Services; Office of Health Equity; and a Center for Minority Veterans.

VHA also has a large portfolio of clinical training programs, including several in the area of cultural and military competence in health care delivery. The Office of Health Equity developed virtual patient cultural competency training under the Employee Education Service contract for the Virtual Medical Center project. Presently, military competence training is available to any provider, and they are encouraged to take the training. Providers currently under contract are not required to complete the course, but future contracts will require completion.

Recommendation #15: Alternative Personnel System

“Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.”

VA finds this recommendation feasible and advisable and is already working as part of VA's MyVA transformation, with some modifications in approach.

VA supports the Commission's legislative proposal recommendation to establish a new alternative personnel system that applies to all VHA employees and falls under

Title 38 authority, provided outside stakeholders support the legislative and policy changes required to create this new system.

VA currently is preparing for consideration a legislative proposal for the FY 2018 budget process to modify 38 United States Code to give the Secretary the authority to establish a human-resources management system unique to VA.

In the absence of a simple-to-administer alternative personnel system, VA has also proposed modifications to existing statutes to provide some relief to the currently complex personnel system and also help with recruitment and retention. These proposals include establishing an appointment and compensation system under Title 38 for VHA occupations of Medical Center Director, VISN Director, and other positions determined by the Secretary that have significant impact on the overall management of VA's health care system. VA is considering proposals to do the following:

- Eliminate Compensation Panels for physicians and dentists, which have been found to be administratively burdensome.
- Eliminate performance pay for physicians and dentists, which has been found to be extremely difficult to administer.
- Establish premium pay for physicians and dentists to allow flexibility in scheduling and eliminate the daily rate paid to these occupations based on 24/7 availability.
- Modify special rate limitation to increase the maximum allowable special rate supplement providing enhanced flexibility to pay competitively within local labor markets.
- Exempt VHA health care providers appointed to positions under 38 U.S.C. 7401 from the dual compensation restrictions for reemployed retired annuitants.

The VHA Strategic Human Resource (HR) Advisory Committee and Workforce Management and Consulting's Human Resource Development group are proposing a comprehensive VHA HR Readiness Program designed to improve the overall operational capabilities of the VHA HR community. The program will identify and integrate all existing and available internal and external training resources into a clear, consistent, and logical roadmap to readiness.

Under the MyVA program, the Staff Critical Positions Initiative was launched to improve hiring of key leadership and other critical positions throughout VHA. VHA is moving ahead with the "Hire Right, Hire Fast" initiative for MSAs. The initiative is being piloted at a number of facilities and will provide products and guidance in 2016, including additional screening for customer service tools, an interview scoring rubric, job posting templates, HR milestone scripts, and much more. These products are designed to increase the supply of MSAs, as well as emphasize the customer service principles and skills needed for success.

VHA has embarked on a Rapid Process Improvement Workshop effort within the HR community to examine the hiring process and identify improvement opportunities, to include operational processes and policies. Plans are also under development to establish a centralized architecture to designate lines of authority in setting training requirements, career paths, etc.

Recommendation #16: Effective Human Capital Management

"Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system."

VA finds the Commission's recommendation both feasible and advisable and is already pursuing the following initiatives as part of VA's MyVA transformation.

Hire Chief Talent Leader and Grant Authorities: VHA currently has a national search underway for its senior most HR executive position. Presently that role does not possess the authority recommended by the commission. It is anticipated that the HR&A transformation program, and the efforts associated with Recommendation 12 in conjunction with the Under Secretary for Health, would work together toward the optimal organization structure for HR across VA and within the administrations including appropriate authorities. This process will help clarify the ideal roles and responsibilities of the VHA Chief Talent Leader.

Transform Human Capital Management: As part of MyVA, VA HR&A has launched the Critical Staffing Initiative to improve the hiring of key leadership and other critical positions throughout the VA. This effort has been working on near-term improvements to hiring medical center directors and other key medical center leaders. So far, this project has identified and is beginning to implement significant improvements to the hiring process and to proliferate hiring best practices across the organization. VA HR&A is currently planning a process to engage stakeholders

across VA to identify next steps for implementing the recommendations outlined in recent study commissioned by VA. A concept paper entitled “VISN HR Shared Service Excellence” is also being evaluated. This concept paper incorporates a number of recommendations contained within the white paper noted above, but with specific emphasis on HR roles within the VISNs and VA Medical Centers. The Commission’s recommendations will be taken into consideration in the process.

Implement Best Practices: The VISN HR Shared Service Excellence paper is heavily weighted toward the sharing of best practices that have been developed in a few highly performing field HR organizations. Best practice sharing is also a significant component of the MyVA Critical Staffing initiative. Also, the HR&A transformation effort is intended to rely heavily on health care and other industry best practice models.

Develop HR Information Technology Plan: The Commission’s recommendation addresses an issue which VA’s early HR transformation efforts are just beginning to address. While there are currently efforts planned and underway to implement HR Smart for personnel and payroll records, and USA Staffing to enable the recruiting process (acknowledged by the Commission), VA would benefit from casting these and other anticipated efforts in a more strategic IT plan. Such a plan would better enable implementation and integration prioritization and capital planning.

Recommendation #17: Eligibility for Other-than-Honorable Service

“Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.”

VA finds this recommendation neither feasible nor advisable.

The Commission’s own estimates indicate this change would cost \$864 million in FY 2019, increasing to \$1.2 billion in FY 2033. This recommendation therefore appears to contemplate health care for anyone with another-than-honorable discharge. While VA agrees with the principle of serving this population of Veterans, the cost of doing so makes the recommendation not feasible at this time.

Many Servicemembers with other-than-honorable discharges qualify for health care for service-connected conditions and other benefits under existing authorities. VA will continue to serve this population. VA is also drafting proposed regulations which will update and clarify 38 C.F.R. §§ 3.12 and 17.34 to improve processes and procedures relating to character of discharge determinations and expand tentative health care eligibility for certain former Servicemembers.

These changes will address many of the concerns raised by the Commission. For example, the rules will provide improved guidance about the consideration of mitigating factors such as extended overseas deployments, mental health conditions, and other extenuating circumstances. Also, VBA has, within the past year, updated its manual to streamline its other-than-honorable adjudicative procedures to expedite health care eligibility determinations and improve the Veteran experience by shortening the wait time.

Recommendation #18: Expert Advisory Body for Defining Eligibility and Benefits

“Establish an expert body to develop recommendations for VA care eligibility and benefits design.”

VA finds this recommendation feasible and advisable.

Substantial changes in the delivery of health care have occurred since Congress last comprehensively examined eligibility for VHA care through passage of Public Law 104–262, Veterans’ Health Care Eligibility Reform Act of 1996, and taking a close look at eligibility criteria in light of current (and projected future) resources and demand makes sense in the context of VA’s ongoing efforts to reshape the future of VA health care. VA will work with the President, Congress, Veterans Service Organizations, and other stakeholders to determine the path forward in the tasking of an expert body to examine and, as appropriate, develop recommendations for changes in eligibility for VA health care benefits.

Recommendation 18 also includes a separate and distinct recommendation for VA to “revise VA regulations to provide that service-connected-disabled Veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.” While VA supports the objective, VA already has regulations (38 C.F.R. 17.49) and policy in place giving priority in scheduling to service-connected Veterans and believes these meet and fulfill the Commission’s intent.

TEXT OF A LETTER FROM THE PRESIDENT

THE WHITE HOUSE

OFFICE OF THE PRESS SECRETARY

For Immediate Release

September 1, 2016

TEXT OF A LETTER FROM THE PRESIDENT**TO THE SPEAKER OF THE HOUSE OF REPRESENTATIVES****AND THE PRESIDENT OF THE SENATE**

SEPTEMBER 1, 2016

Dear Mr. Speaker: (Dear Mr. President:)

My Administration is committed to the ongoing transformation of the Department of Veterans Affairs (VA) and I strongly support many of the recommendations and the underlying objectives offered by the Commission on Care (Commission) in its final report transmitted on July 6, 2016. These recommendations underscore the fundamental challenges that face the VA health care system, and the reforms needed to provide America's veterans with the high quality health care they need and deserve—both now and in the future. We have made great strides in delivering improved care to our veterans over the past 8 years, and we will continue to work tirelessly to uphold the solemn responsibility to ensure all our veterans are getting the care and benefits they have earned.

I concur with 15 of the 18 Commission recommendations, many of which are already being implemented as part of the ongoing MyVA transformation that the Secretary of Veterans Affairs (Secretary) has put in place. These include areas such as enhancing clinical operations, establishing a more consistent policy for appealing clinical decisions, eliminating disparities in how health care is delivered to veterans from different backgrounds, modernizing IT systems, and establishing new processes for leadership development and performance management. These reforms are steps in the right direction and will help put VA on a trajectory to ensure veterans continue to receive timely and high quality care, while strengthening the VA health care system that millions of veterans depend on every day. I appreciate and applaud the Commission for their work.

Of particular note, I strongly support the Commission's principle that creating a high-performing, integrated health care system that encompasses both VA and private care is critical to serving the needs of veterans. In fact, my Administration outlined its approach to achieve this same goal in VA's Plan to Consolidate Community Care, submitted to the Congress in October 2015. While this approach must be implemented in a fiscally sustainable way, it builds on more than a decade of work with veterans, health care providers, and community partners, to streamline and enhance VA's capability to deliver services essential to veterans' health. VA's plan also recognizes the importance of strengthening VA's partnerships with other Federal health care providers, including the Department of Defense and Indian Health Service, as well as tribal health programs, academic teaching affiliates, and Federally Qualified Health Centers.

At the same time, it is critical that we preserve and continue to improve the VA health care system and ensure that VA has the ability to serve veterans. Research shows that in many areas, such as mental health, VA delivers care that is often better than that delivered in the private sector. VA also provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are simply not available to the same extent outside of VA. In addition, VA provides a comprehensive approach to wellness that includes the treatment of physical injuries and mental health. This multidisciplinary approach allows providers to address the full spectrum of veteran needs beyond medical care, including other VA benefits and services.

For these reasons, I concur with the Commission's vision for creating integrated care networks that more tightly coordinate VA and non-VA care, but urge the Congress to act on this recommendation by enacting VA's Plan to Consolidate Community Care. The alternative approach outlined in VA's plan would achieve the goals of the Commission to create a veteran-centric approach to care that appropriately balances issues of access, quality, and cost-effectiveness. It would more clearly en-

sure the long-term viability and sustainability of the VA health care system, preserve VA's role as the primary coordinator of care for veterans, and safeguard its ability to carry out its other research, education, and emergency preparedness missions that are critical to our Nation's well-being. And it would ensure that veterans have access to the care they need—whether at the VA or out in the community—without forcing untenable resource tradeoffs that would limit the ability of VA to carry out other parts of its mission on behalf of veterans.

We must also ensure that VA has the ability to operate this integrated health care system in a rational, efficient, and dynamic way that best serves the interests of both veterans and taxpayers. For that reason, I have concerns with the Commission's proposed governance structure for the VA health care system. The proposal would undermine the authority of the Secretary and the Under Secretary for Health, weaken the integration of the VA health care system with the other services and programs provided by the VA, and make it harder—not easier—for VA to implement transformative change. Moreover, the Department of Justice has advised that the proposed recommendation would violate the Appointments Clause of the Constitution. I do, however, support portions of the recommendation that would establish a term appointment for the Under Secretary for Health, to ensure that position is removed from the turmoil and turnover of the political cycle.

For those recommendations I agree with and whose objectives are not yet achieved, I am directing the VA to develop plans to complete their implementation. Additionally, in recognition of the role of the MyVA initiative in transforming the VA as military service evolves, I have directed the Secretary of Veterans Affairs to incorporate the principles of the MyVA initiative into VA strategic planning, leadership training, and performance monitoring. In those areas where legislation is required, my Administration will work closely with the Secretary to transmit to the Congress the relevant legislative proposals, which I recommend be enacted without delay.

Improving veterans' health care remains a critical issue of national importance, and my Administration will work with veterans and military families, the Congress, Veterans Service Organizations, and other stakeholders to ensure all our veterans are getting the care and benefits they need when they need them.

Sincerely,

BARACK OBAMA

